HEALTH CARE FINANCING ADMINISTRATION

FY 1987 Budget and Legislative Program

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FY 1987

OVERVIEW

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(Includes Third-Party Liability Initative)

ATTACHMENT A

HEALTH CARE FINANCING ADMINISTRATION FY 1987 BUDGET REQUEST TO THE OFFICE OF THE SECRETARY

(Dollars in Millions)

	FY 1985 Appropriation	FY 1986 President's Budget	FY 1986 Revised Estimate	FY 1987 Target	FY 1987 Request	Change From FY 1986	
						$	%
Grants to States/Medicaid	$ 21,845	$ 23,690	$24,135	$26,789	$25,907	$1,772	7.3%
Payments to the Health Care Trust Funds	18,750	19,659	19,175	22,430	20,871	1,696	8.8%
Supplementary Medical Insurance Benefits	22,095	24,991	25,464	28,231	28,139	3,675	10.5%
Hospital Insurance Benefits	47,910	48,246	48,314	52,103	52,254	3,940	8.2%
Peer Review Organizations	122.1	172.3	181.0	--	224.7	43.7	24.1%
Program Management							
Research	34.0	22.0	22.0	22.9	33.0	11.0	50.0%
Medicare Contractors	932.6	935.0	935.0	958.6	1,056.1	121.1	13.0%
State Certification	49.8	49.8	49.8	51.8	60.1	10.3	20.7%
ESRD Networks	4.8	-0-	-0-	--	-0-	--	--
Administrative Costs	221.2	204.6	217.4 1/	213.2	223.9	6.5	3.0%
Total Obligations, Program Management	$ 1,242.4	$ 1,211.4	$1,224.2 1/	$1,246.5	$1,373.1	$148.9	12.3%

1/ Reflects supplemental of $12.8 million to fund additional FTE's and restoration of the FY 1986 proposed 5 percent pay cut.

HEALTH CARE FINANCING ADMINISTRATION
FISCAL YEAR 1987 BUDGET
EXECUTIVE SUMMARY

The proposed FY 1987 current law budget is $107.9 billion. These funds will allow the Health Care Financing Administration (HCFA) to achieve its program objectives by continuing efforts started in prior years. These objectives are to:

- promote competition in the health care market place;
- minimize unnecessary Federal intrusion through the reduction or simplification of regulatory burden;
- reduce fraud, waste and abuse in Medicare and Medicaid;
- promote efficiency, economy and improved management in HCFA's programs and internal administration.

The HCFA current law request for FY 1987 represents an increase of $8.6 billion, or 8.7 percent, over FY 1986.

CURRENT LAW

GRANTS TO STATES FOR MEDICAID

The FY 1987 appropriation request for Grants to States for Medicaid, based on the May State estimates, totals $25.9 billion. The request represents a $1.8 billion, or 7.3 percent, increase over the current FY 1986 estimate. The increase is almost totally attributable to growth in medical assistance payments (MAP). Over 70 percent of the growth in MAP is due to price inflation, the majority of which occurs in institutional services.

The cost of medical care for FY 1987 is distributed among the major service categories as follows:

	% OF HEALTH CARE COSTS FOR FY 1987
Inpatient Hospital	23.8
Skilled Nursing Facility	12.9
ICF/All Other	16.1
ICF/Mentally Retarded	11.9
Prescribed Drugs	6.1
Outpatient Hospital	4.4
Physician	6.1
Mental Health Facility	3.1
Other	15.6
TOTAL	100.0

New York State and California together account for $600 million of the increase in medical care costs. The State of Florida is also projecting an increase of nearly $150 million largely due to the addition of a medically needy program. In total, these three States account for over 40% of the FY 1987 growth in Medicaid expenditures.

MEDICARE BENEFITS

Medicare Benefits, based on the Spring Review economic assumptions, will total approximately $80.5 billion during FY 1987, an increase of approximately $6.5 billion or 9.0 percent over FY 1986.

For Part A

- upward changes in reimbursement per unit of service account for 63.6 percent of the increase;
- changes in enrollment account for 19.1 percent of the change;
- changes in admissions per capita and days of care per capita account for 17.3 percent.

For Part B

- 17.2 percent of the increase is the result of changes in physician fees;
- 26.2 percent is due to changes in utilization and other factors related to physician services;
- 26.5 percent is due to higher reimbursement and utilization of outpatient services;
- 17.3 percent is due to growth in enrollment;
- 11.8 percent is due to other benefit increases;
- 1 percent is due to the static deductible.

Peer Review Organizations

- The second round of 2-year contracts with Peer Review Organizations (PROs) will be negotiated toward the end of FY 1986. The estimated obligation level for these contracts is $470 million. FY 1987 PRO outlays are expected to total $224.7 million.
- PROs will conduct reviews in the following areas:
    - Inpatient hospital services ($387.2 million)
    - Outpatient surgeries ($78.8 million)
    - HMO ambulatory services ($4.0 million)
- In accordance with the Social Security Amendments of 1983, reviews of inpatient hospital services will be supported by a direct transfer from the Federal Hospital Insurance (HI) Trust Fund.

- Reviews of HMO ambulatory services and outpatient surgeries will be supported by a direct transfer from the Federal Supplementary Medical Insurance (SMI) Trust Fund.

PROGRAM MANAGEMENT

The request for activities in the Program Management account provides the minimum funding level necessary for HCFA to meet the responsibilities inherent in the management of a $107.9 billion budget.

The total Program Management request represents only 1.3 percent of the total budget for which HCFA has responsibility. The Administrative Costs (salaries and expenses) request is only .2 of one percent.

- Research - The FY 1987 request of $33.0 million represents an increase of 66.7 percent over the FY 1986 President's budget and restores this program to a level approximately equal to the 1984/85 budgets. This budget request is the result of a painstaking process initiated about a year ago to improve the mangement focus of this program. Each project for which funds are being requested can be linked to short, mid, and long - term objectives.

- Medicare Contractors - The FY 1987 request of $1,056.1 million will maintain the FY 1986 program level and requests a major program increase to develop and maintain model claims processing systems. This budget request is based upon the assumption that further reductions in administrative savings should be deemphasized in favor of continuing efforts to save program dollars.

- State Certification - The FY 1987 request of $60.1 million will provide an increase of 21 percent over the FY 1986 President's budget. The increase in this activity is primarily attributable to inflation and workload increases. The amount requested includes increases in survey coverage levels for hospitals to ensure that all sub-standard facilities are identified. Coverage of Home Health Agencies will be expanded to provide actual visits to the beneficiaries' homes to further ensure program compliance. In addition, these funds will cover complete formal surveys of all psychiatric facilities. This will ensure that national consistency is applied as opposed to individual state discretion.

- Administrative Costs - This budget includes a FY 1986 supplemental request of $12.8 million. This request is needed to pay the salary and support costs consistent with an FTE ceiling of 3,935 and to restore salary costs eliminated from the FY 1986 President's Budget request in anticipation of the proposed 5 percent employee pay reduction. The FY 1987 request of $258.0 million will support a staffing level of 3,800 FTEs. This funding and resource level will enable HCFA to maintain effective and efficient management of the Medicare and Medicaid programs. Included in this request is $34.1 million in proposed multi-year authority to continue the implementation of HCFA's long-range data initiative, Project to Redesign Information Systems Management (PRISM). This multi-year funding authority will enable HCFA to more effectively manage this program on a long-range basis.

HHS-Related Grace Commission Recommendations
(In millions of dollars)

I. Items Included for the First Time

Cost Control Item(s)	Grace 3-Year Savings	HHS FY 1987 Budget	HHS Rationale
Test direct link between HCFA and providers; (HCFA 6-3)	$ 324	$ 7	Pilot test of the direct link between HCFA and providers (SPIDER) to be completed by 10/86; nationwide implementation in FY 87.

II. Cumulative Savings - Past and Current Items

Cost Control Item(s)	Grace 3-Year Savings	Actual Savings Through FY 1986	Projected Savings FY 1987	HHS Rationale
Improve Medicare contractor audit and medical review reporting and procedures;increase audit and medical review budgets. (HCFA 2-1, 2-2)	$ 447	$3,920	$ 1,145	Savings based upon the following ratios: 5 to 1 for Medicare contractor audits and Part A MR/UR 7.84 to 1 for Part B MR/UR
Adopt a Medicare PPS for hospitals. (HCFA 3-1)	5,600	10,105	8,956	Savings based on levels consistent with TEFRA savings for FY 1984 - 1985 (budget neutrality); includes savings from FY 1986 initiatives to freeze PPS rates and payments for direct graduate medical education costs, and to reduce payments for indirect graduate medical education costs.
Implement negotiated fee schedule for physicians. (HCFA 4-1)	3,353	1,250	700	Savings based on the 15 month physician fee freeze imposed by DEFRA and the FY 1986 legislative proposal to extend freeze for additional 12 months.
Recommend staffing level of 4,161 FTEs. (HCFA 8-1)	33 (-966 FTEs)	70 (-1814 FTEs)	28 (-683 FTEs)	Reduction in FTEs over FY 1982 base (4,483): FY FTEs 1983 4,090 1984 4,055 1985 4,038 1986 3,935 1987 3,800
Limit on total Medicare and Medicaid spending, with increases tied to overall economic growth. (FHCC-1)	16,300	2,214	3,693	Savings based on DEFRA (excluding physician fee freeze) and the FY 1986 proposal to cap Medicaid expenditures.

II. Cumulative Savings - Past and Current Items (cont.)

Cost Control Item(s)	Grace 3-Year Savings	Actual Savings Through FY 1986	Projected Savings FY 1987	HHS Rationale
Remove Medicare administration from the RRB. (BANK 16)	$ 23.9	$ 2	$ 2	Savings based upon the FY 1986 legislative proposal to remove Medicare administration from the RRB.

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
TOTAL BUDGET AUTHORITY									
1) MEDICAID									
a) CURRENT LAW	21,845,491	24,384,815	(24,384,815)		25,907,488	28,642,300	31,347,800	34,331,200	
b) PROPOSED LAW	0	0	0		0	0	0	0	
SUBTOTAL	21,845,491	24,384,815	(24,384,815)		25,907,488	28,642,300	31,347,800	34,331,200	
2) PROGRAM MANAGEMENT									
a) CURRENT LAW	97,354	82,399	(82,399)		133,516	101,214	102,944	104,593	
b) PROPOSED LAW	0	0	0		0	0	0	0	
SUBTOTAL	97,354	82,399	(82,399)		133,516	101,214	102,944	104,593	
3) HOSPITAL INSURANCE									
a) CURRENT LAW	52,645,000	61,919,000	(61,919,000)		69,342,270	69,335,000	74,622,000	80,557,000	
b) PROPOSED LAW	0	0	0		107,000	160,000	383,000	730,000	
SUBTOTAL	52,645,000	61,919,000	(61,919,000)		69,449,270	69,495,000	75,005,000	81,287,000	
4) SUPPLEMENTARY MEDICAL INSURANCE									
a) CURRENT LAW	24,451,000	25,479,000	(25,479,000)		27,693,000	31,274,000	37,013,000	42,227,000	
b) PROPOSED LAW	0	0	0		(481,000)	(705,000)	(735,000)	(867,000)	
SUBTOTAL	24,451,000	25,479,000	(25,479,000)		27,212,000	30,569,000	36,278,000	41,360,000	
TOTAL B.A. CURRENT LAW	99,039,845	111,865,214	(111,865,214)		123,076,274	129,352,514	143,085,744	157,219,793	
TOTAL B.A. PROPOSED LAW	0	0	0		(374,000)	(545,000)	(352,000)	(137,000)	
TOTAL B.A. NET PROPOSED LAW	99,039,845	111,865,214	(111,865,214)		122,702,274	128,807,514	142,733,744	157,082,793	

(dollars in thousands)

	FY 1985	» »» »» »» »» REVISED ESTIMATE	FY 1986 CHANGE	» »» »» »» »» CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
TOTAL OUTLAYS									
1) MEDICAID a) CURRENT LAW	22,812,753	24,414,100	(106,759)	24,307,341	25,907,488	28,642,399	31,347,800	34,331,200	
b) PROPOSED LAW	0	0	0	0	0	0	0	0	
SUBTOTAL	22,812,753	24,414,100	(106,759)	24,307,341	25,907,488	28,642,399	31,347,800	34,331,200	
2) PROGRAM MANAGEMENT a) CURRENT LAW	97,354	82,399	4,976	87,374	99,416	108,544	106,867	104,593	
b) PROPOSED LAW	0	0	0	0	0	0	0	0	
SUBTOTAL	97,354	82,399	4,976	87,374	99,416	108,544	106,867	104,593	
3) HOSPITAL INSURANCE a) CURRENT LAW	48,701,547	49,177,911	0	49,177,911	53,171,189	58,891,399	65,094,898	71,731,200	
b) PROPOSED LAW	0	0	0	0	(1,163,000)	(1,751,000)	(2,141,000)	(2,376,000)	
SUBTOTAL	48,701,547	49,177,911	0	49,177,911	52,008,189	57,140,399	62,953,898	69,355,200	
4) SUPPLEMENTARY MEDICAL INSURANCE a) CURRENT LAW	22,439,256	26,472,742	8,720	26,481,462	29,272,980	32,960,019	37,051,677	41,693,057	
b) PROPOSED LAW	0	0	(10,000)	(10,000)	(662,000)	(700,000)	(685,000)	(860,000)	
SUBTOTAL	22,439,256	26,472,742	(1,280)	26,471,462	28,610,980	32,260,019	36,366,677	40,833,057	
TOTAL OUTLAYS, CURRENT LAW	94,050,910	100,147,152	(93,063)	100,054,088	108,451,073	120,602,262	133,601,152	147,860,050	
TOTAL OUTLAYS, PROPOSED LAW	0	0	(10,000)	(10,000)	(1,825,000)	(2,451,000)	(2,826,000)	(3,236,000)	
TOTAL OUTLAYS, NET PROPOSED LAW	94,050,910	100,147,152	(103,063)	100,044,088	106,626,073	118,151,262	130,775,152	144,624,050	

(dollars in thousands)

	FY 1985	REVISED ESTIMATE	FY 1986 CHANGE	CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
TOTAL APPROPRIATION									
1) MEDICAID									
a) CURRENT LAW	21,845,491	24,384,815	(249,323)	24,135,492	25,907,488	28,642,300	31,347,800	34,331,200	
b) PROPOSED LAW	0	0	0	0	0	0	0	0	
SUBTOTAL	21,845,491	24,384,815	(249,323)	24,135,492	25,907,488	28,642,300	31,347,800	34,331,200	
2) PROGRAM MANAGEMENT									
a) CURRENT LAW	97,354	82,399	4,976	87,374	133,516	101,214	102,944	104,593	
b) PROPOSED LAW	0	0	0	0	0	0	0	0	
SUBTOTAL	97,354	82,399	4,976	87,374	133,516	101,214	102,944	104,593	
3) PAYMENTS TO HEALTH CARE TRUST FUNDS									
a) CURRENT LAW	18,750,000	19,175,000	0	19,175,000	20,871,000	24,149,000	29,631,000	34,394,000	
b) PROPOSED LAW	0	0	(719,000)	(719,000)	(1,468,000)	(2,601,000)	(4,464,000)	(6,504,000)	
SUBTOTAL	18,750,000	19,175,000	(719,000)	18,456,000	19,403,000	21,548,000	25,167,000	27,890,000	
TOTAL APPROPRIATION, CURRENT LAW	40,692,845	43,642,214	(244,347)	43,397,866	46,912,004	52,892,514	61,081,744	68,829,793	
TOTAL APPROPRIATION, PROPOSED LAW	0	0	(719,000)	(719,000)	(1,468,000)	(2,601,000)	(4,464,000)	(6,504,000)	
TOTAL APPROPRIATION, NET P.L.	40,692,845	43,642,214	(963,347)	42,678,866	45,444,004	50,291,514	56,617,744	62,325,793	

08-Jul-85 --FY 1987 BUDGET

(dollars in thousands)

	FY 1985	* ** ** ** **	FY 1986	* ** ** ** **	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
GRANTS TO STATES FOR MEDICAID		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
1) MEDICAL ASSISTANCE PAYMENTS									
a) State Estimates (5/85)	21,693,387	24,044,096	(154,195)	23,889,901	25,714,596	28,558,000	31,365,000	34,402,000	37,750,000
Adjustments	(300,000)	(760,000)	110,000	(650,000)	(800,000)	(900,000)	(1,000,000)	(1,100,000)	(1,200,000)
	21,393,387	23,284,096	(44,195)	23,239,901	24,914,596	27,658,000	30,365,000	33,302,000	36,550,000
b) Prior Year Claims	122,047	0	0	0	0	0		0	0
c) TPL Savings	0	(111,700)	(88,300)	(200,000)	(300,000)	(350,000)	(400,000)	(400,000)	(400,000)
d) NOC Disallowances	(53,000)	0	(17,500)	(17,500)	(50,000)	(50,000)	(50,000)	(50,000)	(50,000)
d) OBRA	345,348	0	0	0	0	0	0	0	0
e) Financial Adjustments	(210,000)	0	0	0	0	0	0	0	0
d) Regulatory Impact	0	0	0	0	(5,000)	(25,000)	(30,000)	(35,000)	(35,000)
e)									0
SUBTOTAL, MEDICAL ASSISTANCE OUT.	21,597,782	23,172,396	(149,995)	23,022,401	24,559,596	27,233,000	29,885,000	32,817,000	36,065,000
SUBTOTAL, OBL. WHERE DIFF. FROM OUT.									
2) STATE AND LOCAL ADMINISTRATION									
a) State Estimates (5/85)	1,167,664	1,191,988	55,210	1,247,198	1,305,138	1,362,600	1,417,000	1,469,500	1,523,900
b) Regulatory Impact	0	0	0	0	0	0	0	0	0
c) OBRA	19,203	0	0	0	0	0	0	0	0
d) Financial & Other Adjustments	(40,000)	(40,000)	(10,000)	(50,000)	(50,000)	(50,000)	(55,000)	(60,000)	(60,000)
SUBTOTAL, S&L ADMINISTRATION	1,146,867	1,151,988	45,210	1,197,198	1,255,138	1,312,600	1,362,000	1,409,500	1,463,900
3) STATE CERTIFICATION									
a) State Estimates (5/85)	39,610	46,785	(1,974)	44,811	48,601	50,700	52,800	54,700	56,700
b) OBRA	0	0	0	0	0	0	0	0	0
c) Financial Adjustments	0	0	0	0	0	0	0	0	0
SUBTOTAL, STATE CERTIFICATION	39,610	46,785	(1,974)	44,811	48,601	50,700	52,800	54,700	56,700
4) FRAUD CONTROL UNITS	28,494	42,731	0	42,731	44,153	46,000	48,000	50,000	52,000
SUBTOTAL, ALL ADMIN (2-4). OUT.	1,214,971	1,241,704	43,236	1,284,940	1,347,892	1,409,300	1,462,800	1,514,200	1,572,600
SUBTOTAL, OBL. WHERE DIFF. FROM OUT.									
TOTAL OBLIGATIONS/OUTLAYS C.L.	22,812,753	24,414,100	(106,759)	24,307,341	25,907,488	28,642,300	31,347,800	34,331,200	37,637,600
TOTAL OBL. WHERE DIFF. FROM OUT.									
UNOBLIGATED BALANCE									
o Start of Year	(1,017,064)	(74,285)	(97,564)	(171,849)	0	0	0	0	(0)
o End of Year	171,847	45,000	(45,000)	0	0	0	0	0	0
o Prior Year Claims	(122,047)								
APPROPRIATION/ BA	21,845,491	24,384,815	(249,323)	24,135,492	25,907,488	28,642,300	31,347,800	34,331,200	37,637,600
o Advanced Appropriation	5,552,000	5,980,000	0	5,980,000	6,500,000	6,917,115	7,570,494	8,290,985	9,089,480
o Remaining Appropriation	16,293,491	18,404,815	(249,323)	18,155,492	19,407,488	21,725,185	23,777,306	26,040,215	28,548,120

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
GRANTS TO STATES FOR MEDICAID P.L.									
1) MEDICAL ASSISTANCE PAYMENTS									
a) Medicaid Cost Limits	0	0	0	0	0	0	0	0	0
b) S&L Adm. Cost Freeze	0	0	0	0	0	0	0	0	0
a) Freeze Physician Fees	0	0	0	0	0	0	0	0	0
b) Part B Premium Increase	0	0	0	0	0	0	0	0	0
c) Freeze SMI Deduct.	0	0	0	0	0	0	0	0	0
c) Elim. CPI Update Clin. Labs	0	0	0	0	0	0	0	0	0
d) Delay Initial Eligibil. Date	0	0	0	0	0	0	0	0	0
i) Lower Reimb for DME	0	0	0	0	0	0	0	0	0
g) Impact of AFDC	0	0	0	0	0	0	0	0	0
j)	0	0	0	0	0	0	0	0	0
Total B.A./Outlays Proposed law	0	0	0	0	0	0	0	0	0
TOTAL APPROPRIATION / BA, NET P.L.	21,845,491	24,384,815	(249,323)	24,135,492	25,907,488	28,642,300	31,347,800	34,331,200	37,637,600
TOTAL OUTLAYS NET P.L.	22,812,753	24,414,100	(106,759)	24,307,341	25,907,483	28,642,300	31,347,900	34,331,200	37,637,600

	FY 1985	* ** ** ** **	FY 1986	* ** ** ** **	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
		REVISED ESTIMATE	CHANGE	CURRENT ESTIMATE					
PROGRAM MANAGEMENT, CURRENT LAW									
BUDGET AUTHORITY									
1) PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS									
a) Program Level	0	0	0	0	0	0	0	0	
b) Less Hospital Review	0	0	0	0	0	0	0	0	
Subtotal, Obligations	0	0	0	0	0	0	0	0	
c) Less Trust Fund Transfer	0	0	0	0	0	0	0	0	
PSRO B.A.	0	0	0	0	0	0	0	0	
2) RESEARCH									
a) Program Level	34,000	22,000	0	22,000	33,000	34,320	35,590	36,800	38,051
b) Less Trust Fund Transfer	(11,650)	(7,700)	0	(7,700)	(11,000)	(11,440)	(11,863)	(12,266)	(12,683)
RESEARCH B.A.	22,350	14,300	0	14,300	22,000	22,880	23,727	24,534	25,368
3) MEDICARE CONTRACTORS									
3A) Claims Processing									
a) Program Level	702,100	700,700	2,900	703,600	809,600	841,640	877,055	905,816	936,570
b) Less Trust Fund Transfer	(702,100)	(700,700)	(2,900)	(703,600)	(809,600)	(841,640)	(877,055)	(905,816)	(936,570)
Claims Processing B.A.	0	0	0	0	0	0	0	0	0
3b) Payment Safeguards									
a) Program Level	190,500	202,800	7,000	209,800	218,900	227,656	236,079	244,106	252,406
b) Less Trust Fund Transfer	(190,500)	(202,800)	(7,000)	(209,800)	(218,900)	(227,656)	(236,079)	(244,106)	(252,406)
Payment Safeguards B.A.	0	0	0	0	0	0	0	0	0
3c) Productivity Investments									
a) Program Level	40,000	16,500	5,100	21,600	27,600	28,704	29,766	30,778	31,824
b) Less Trust Fund Transfer	(40,000)	(16,500)	(5,100)	(21,600)	(27,600)	(28,704)	(29,766)	(30,778)	(31,824)
Productivity Investments B.A.	0	0	0	0	0	0	0	0	0
a) Total CONTRACTOR Program Level	932,600	920,000	15,000	935,000	1,056,100	1,098,000	1,142,900	1,180,700	1,220,800
b) Less Total Trust Fund Transfer	(932,600)	(920,000)	(15,000)	(935,000)	(1,056,100)	(1,098,000)	(1,142,900)	(1,180,700)	(1,220,800)
TOTAL CONTRACTOR B.A.	0	0	0	0	0	0	0	0	0

(dollars in thousands)

	FY 1985	* ** ** ** **	FY 1986	* ** ** ** **	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
		REVISED ESTIMATE	CHANGE	CURRENT ESTIMATE					
4) STATE CERTIFICATION									
a) Program Level	49,759	49,759	0	49,759	60,069	66,609	73,300	89,212	87,324
b) Less Trust Fund Transfer	(47,074)	(48,434)	0	(48,434)	(56,544)	(63,083)	(69,775)	(85,687)	(83,799)
STATE CERTIFICATION B.A.	2,685	1,325	0	1,325	3,525	3,525	3,525	3,525	3,525
5) ESRD NETWORKS									
a) Program Level	4,837	0	0	0	0	0	0	0	0
b) Less Trust Fund Transfer	(4,837)	0	0	0	0	0	0	0	0
ESRD NETWORK B.A.	0	0	0	0	0	0	0	0	0
6) ADMINISTRATIVE COSTS									
a) Program Level	221,227	204,600	12,821	217,421	258,012 *	226,694	229,370	231,920	234,557
b) Less Trust Fund Transfer	(148,908)	(137,827)	(7,845)	(145,672)	(159,021)	(151,885)	(153,678)	(155,386)	(157,153)
ADMINISTRATIVE COSTS B.A.	72,319	66,773	4,976	71,749	85,144	74,809	75,692	76,534	77,404
TOTAL PROG LEVEL (LESS PSRO HR)	1,242,423	1,196,359	27,321	1,224,120	1,407,181	1,425,622	1,481,160	1,529,632	1,580,732
TOTAL TRUST FUND TRANSFER	(1,145,069)	(1,113,960)	(22,845)	(1,136,806)	(1,273,665)	(1,324,408)	(1,378,216)	(1,425,039)	(1,474,435)
TOTAL PROGRAM MANAGEMENT B.A.	97,354	82,399	4,976	87,374	133,516	101,214	102,944	104,593	106,297

* Includes proposed multi-year funding of $34,100,000 to fund PRISM.

GENERAL FUND OUTLAYS									
1) RESEARCH	22,350	14,300	0	14,300	22,000	22,880	23,727	24,534	25,368
2) STATE CERTIFICATION	2,685	1,325	0	1,325	3,525	3,525	3,525	3,525	3,525
3) ADMINISTRATIVE COSTS	72,319	66,773	4,976	71,749	73,891	82,139 **	79,615 **	76,534	77,404
TOTAL PROGRAM MANAGEMENT OUTLAYS	97,354	82,399	4,976	87,374	99,416	108,544	106,867	104,593	106,297

** Includes $7,330,000 and $3,923,000 respectively in outlays associated with the multi-year funding of PRISM.

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	
PROGRAM MANAGEMENT, PROPOSED LAW										
1) Process Part A on Flow Basis	0	0	0	0	(3,000)	(4,000)	(4,000)	(4,000)	(5,000)	
Less Trust Fund Transfer	(0)	(0)	0	0	3,000	4,000	4,000	4,000	5,000	
B.A. / Outlays	0	0	0	0	0	0	0	0	0	
2) Contractor Process RRB Claims	0	0	0	0	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	
Less Trust Fund Transfer	(0)	(0)	0	0	2,000	2,000	2,000	2,000	2,000	
B.A. / Outlays	0	0	0	0	0	0	0	0	0	
3)	0	0	0	0	0	0	0	0	0	
Less Trust Fund Transfer	0	0	0	0	0	0	0	0	0	
B.A. / Outlays	0	0	0	0	0	0	0	0	0	
4)	0	0	0	0	0	0	0	0	0	
Less Trust Fund Transfer	(0)	(0)	0	0	0	0	0	0	0	
B.A. / Outlays	0	0	0	0	0	0	0	0	0	
5)	0	0	0	0	0	0	0	0	0	
Less Trust Fund Transfer	(0)	(0)	0	0	0	0	0	0	0	
B.A. / Outlays	0	0	0	0	0	0	0	0	0	
TOTAL PROGRAM LEVEL, PROPOSED LAW	0	0	0	0	(5,000)	(6,000)	(6,000)	(6,000)	(7,000)	
TOTAL TRUST FUND TRANSFER, P.L.	0	0	0	0	5,000	6,000	6,000	6,000	7,000	
TOTAL B.A./OUTLAYS, P.L.	0	0	0	0	0	0	0	0	0	
TOTAL PROGRAM LEVEL NET P.L.	1,242,423	1,196,359	27,821	1,224,180	1,402,181	1,419,622	1,475,160	1,523,632	1,573,732	
TOTAL TRUST FUND TRANSFER NET P.L.	(1,145,069)	(1,113,960)	(22,845)	(1,136,806)	(1,268,665)	(1,318,408)	(1,372,216)	(1,419,039)	(1,467,435)	
TOTAL B.A. NET PROPOSED LAW	97,354	82,399	4,976	87,374	133,516	101,214	102,944	104,593	106,297	0
TOTAL OUTLAYS NET PROPOSED LAW	97,354	82,399	(1,219,204)	(1,136,896)	(1,268,665)	(1,318,408)	(1,372,216)	(1,419,039)	(1,467,435)	

(dollars in thousands)

	FY 1985	* ** ** ** **	FY 1986	* ** ** ** **	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
		REVISED ESTIMATE	CHANGE	CURRENT ESTIMATE					
PAYMENTS TO HEALTH CARE TRUST FUNDS									
B.A./OUTLAYS, CURRENT LAW									
1) MILITARY SERVICE CREDITS	86,000	91,000	0	91,000	92,000	94,000	95,000	96,000	
2) HI FOR THE UNINSURED	762,000	554,000	0	554,000	568,000	533,000	476,000	456,000	
3) HI FOR UNINSURED FEDERAL			0						
ANNUITANTS AND EMPLOYEES	4,000	12,000	0	12,000	13,000	16,000	17,000	17,000	
4) FEDERAL CONTRIBUTION FOR SMI	17,898,000	18,518,000	0	18,518,000	20,198,000	23,506,000	29,023,000	33,825,000	
SUBTOTAL, APPROPRIATION C.L.	18,750,000	19,175,000	0	19,175,000	20,871,000	24,149,000	29,631,000	34,394,000	
5) SECA CREDITS	496,000	419,000	0	419,000	423,000	446,000	461,000	324,000	
TOTAL B.A., CURRENT LAW	19,246,000	19,594,000	0	19,594,000	21,294,000	24,595,000	30,092,000	34,718,000	
TOTAL OUTLAYS, CURRENT LAW	19,246,000	19,594,000	0	19,594,000	21,294,000	24,595,000	30,092,000	34,718,000	
B.A./OUTLAYS, PROPOSED LAW									
1) HI FOR THE UNINSURED	0	0	0	0	0	(19,000)	(20,000)	(19,000)	(17,000)
2) HI FOR UNINSURED FEDERAL	0	0	0	0	0	0	(1,000)	(1,000)	(1,000)
ANNUITANTS AND EMPLOYEES									
3) FEDERAL CONTRIBUTION FOR SMI	0	0	0	0	(719,000)	(1,449,000)	(2,580,000)	(4,444,000)	(6,486,000)
TOTAL B.A./OUTLAYS, P.L.	0	0	0	0	(719,000)	(1,468,000)	(2,601,000)	(4,464,000)	(6,504,000)
	18,750,000	19,175,000	977,000	19,175,000	20,152,000	22,681,000	27,030,000	29,930,000	(6,504,000)
TOTAL B.A., NET PROPOSED LAW	19,246,000	19,594,000	981,000	19,594,000	20,575,000	23,127,000	27,491,000	30,254,000	(6,504,000)
TOTAL OUTLAYS, NET PROPOSED LAW	19,246,000	19,594,000	981,000	19,594,000	20,575,000	23,127,000	27,491,000	30,254,000	(6,504,000)

09-Jul-85 --FY 1987 BUDGET

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
TOTAL TRUST FUNDS									
INCOME, CURRENT LAW									
Income w/o Off Receipts	71,551,000	81,489,000	0	81,489,000	90,460,270	93,531,000	104,138,000	114,863,000	
Offsetting Receipts	5,545,000	5,909,000	0	5,909,000	6,575,000	7,078,000	7,497,000	7,921,000	
TOTAL INCOME , CURRENT LAW	77,096,000	87,398,000	0	87,398,000	97,035,270	100,609,000	111,635,000	122,784,000	
INCOME, PROPOSED LAW									
Income w/o Off Receipts	0	0	0	0	107,000	160,000	385,000	732,000	
Offsetting Receipts	0	0	221,000	221,000	723,000	1,827,000	3,555,000	5,366,000	
TOTAL INCOME , PROPOSED LAW	0	0	221,000	221,000	830,000	1,987,000	3,940,000	6,098,000	
TOTAL INCOME W/OUT OFF RECEIPTS NET PROPOSED LAW	71,551,000	81,489,000	0	81,489,000	90,567,270	93,691,000	104,523,000	115,595,000	
TOTAL OFF. RECEIPTS NET P.L.	5,545,000	5,909,000	221,000	6,130,000	7,298,000	8,905,000	11,052,000	13,287,000	
TOTAL INCOME , NET PROPOSED LAW	77,096,000	87,398,000	221,000	87,619,000	97,865,270	102,596,000	115,575,000	128,882,000	
OUTLAYS, CURRENT LAW									
Benefits	69,342,945	73,777,698	34	73,777,732	80,393,553	89,684,182	99,892,015	111,091,045	
Administration	1,675,803	1,700,653	0	1,700,653	1,325,734	1,721,980	1,988,523	2,044,671	
Peer Review Organizations	122,055	172,302	(34)	172,268	186,047	201,118	216,185	232,155	
Interest to Treasury	0	0	0	0	0	0	0	0	
TOTAL OUTLAYS, CURRENT LAW	71,140,803	75,650,653	0	75,650,653	82,405,534	91,807,280	102,096,723	113,367,871	
TOTAL OUTLAYS, CURRENT LAW, NET OF OFFSETTING RECEIPTS	65,595,803	69,741,653	0	69,741,653	75,830,534	84,729,280	94,599,723	105,446,871	
OUTLAYS, PROPOSED LAW									
Benefits	0	0	(10,000)	(10,000)	(1,820,000)	(2,445,000)	(2,820,000)	(3,230,000)	
Administration	0	0	0	0	(5,000)	(6,000)	(6,000)	(6,000)	
TOTAL OUTLAYS, PROPOSED LEG.	0	0	(10,000)	(10,000)	(1,825,000)	(2,451,000)	(2,826,000)	(3,236,000)	
TOTAL OUTLAYS, P.L., NET O.R.	0	0	(231,000)	(231,000)	(2,548,000)	(4,278,000)	(6,381,000)	(8,602,000)	
OUTLAYS, NET PROPOSED LAW									
Benefits	69,342,945	73,777,698	(9,966)	73,767,732	78,573,553	87,239,182	97,072,015	107,861,045	
Administration	1,797,858	1,872,955	(34)	1,872,921	2,006,981	2,117,078	2,198,708	2,270,826	
TOTAL OUTLAYS, NET P.L.	71,140,803	75,650,653	(10,000)	75,640,653	80,580,534	89,356,260	99,270,723	110,131,871	
TOTAL OUTLAYS, NET P.L., NET OF OFFSETTING RECEIPTS	65,595,803	69,741,653	(231,000)	69,510,653	73,282,534	80,451,260	88,218,723	96,844,871	

	FY 1985	* ** ** ** **	FY 1986	* ** ** ** **	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
		REVISED ESTIMATE	CHANGE	CURRENT ESTIMATE					
FEDERAL HOSPITAL INSURANCE (HI)									
HI INCOME, CURRENT LAW									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) FICA	39,166,000	43,474,000	0	43,474,000	47,898.000	52,340,000	54,519,000	61,175,000	
b) SECA	1,933,000	2,292,000	0	2,292,000	2,695,000	2,793,000	3,012,000	3,352,000	
c) Refunds	(110,000)	(124,000)	0	(124,000)	(147,000)	(171,000)	(193,000)	(214,000)	
d) Deposits by States	4,308,000	5,002,000	0	5,002,000	5,435,000	5,792,000	6,014,000	6,564,000	
e) RRB Transfer	321,000	336,000	0	336,000	364,000	378,000	384,000	389,000	
f) Fed Employer Contrib	1,269,000	1,356,000	0	1,356,000	1,445,000	1,530,000	1,603,000	1,725,000	
g) Fed Employer Contrib (Postal)	186,000	206,000	0	206,000	223,000	236,000	245,000	259,000	
h) General Fund Transfer	1,348,000	1,076,000	0	1,076,000	1,096,000	1,067,000	1,069,000	893,000	
i) Interest	2,090,000	2,766,000	0	2,766,000	4,069,000	5,201,000	5,821,000	6,267,000	
j) RRB Interest	47,000	43,000	0	43,000	42,000	39,000	27,000	22,000	
k) OASI Repayment	1,824,000	4,600,000	0	4,600,000	6,013,270	0	0	0	
l) Interest from OASI	1,206,000	811,000	0	811,000	215,000	0	0	0	
m) Interest on Overpayments	8,000	8,000	0	8,000	8,000	8,000	8,000	8,000	
TOTAL INCOME W/OUT OFFSETTING RECEIPTS	52,596,000	61,846,000	0	61,846,000	69,256,270	69,240,000	74,516,000	80,440,000	
2)OFFSETTING RECEIPTS									
a) Premiums Collected	44,000	53,000	0	53,000	61,000	65,000	71,000	77,000	
b) ESRD TPL Collections	15,000	20,000	0	20,000	25,000	30,000	35,000	40,000	
TOTAL OFFSETTING RECEIPTS	59,000	73,000	0	73,000	86,000	95,000	106,000	117,000	
TOTAL INCOME, CURRENT LAW	52,645,000	61,919,000	0	61,919,000	69,342,270	69,335,000	74,622,000	80,557,000	

(dollars in thousands)

	FY 1985	REVISED ESTIMATE	FY 1986 CHANGE	CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
HI INCOME, PROPOSED LAW									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) Deposits by States	0	0	0		72,000	4,000	58,000	230,000	24,000
b) General Fund Transfer	0	0	0		0	(19,000)	(21,000)	(20,000)	(13,000)
c) Interest on Investments	0	0	0		35,000	175,000	348,000	522,000	698,000
SUBTOTAL, INCOME W/OUT OFFSETTING RECEIPTS	0	0	0	0	107,000	160,000	395,000	732,000	704,000
2)OFFSETTING RECEIPTS									
a) Premiums Collected	0	0	0		0	0	(2,000)	(2,000)	(3,000)
SUBTOTAL, OFFSETTING RECEIPTS	0	0	0	0	0	0	(2,000)	(2,000)	(3,000)
TOTAL INCOME, PROPOSED LEGISLATION	0	0	0	0	107,000	160,000	393,000	730,000	701,000
TOTAL INCOME W/OUT OFF RECEIPTS NET PROPOSED LAW	52,586,000	61,846,000	0	61,846,000	69,363,270	69,400,000	74,901,000	81,172,000	704,000
TOTAL OFF RECEIPTS NET P.L.	59,000	73,000	0	73,000	86,000	95,000	104,000	115,000	(3,000)
TOTAL INCOME NET PROPOSED LAW	52,645,000	61,919,000	0	61,919,000	69,449,270	69,495,000	75,005,000	81,287,000	701,000

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
HI OUTLAYS , CURRENT LAW									
1) BENEFITS									
a) Base	47,751,945	50,276,698	34	50,276,732	55,176,953	61,085,892	67,722,815	74,826,845	
b) Hospital Reviews	0	0	0	0	0	0	0	0	
c) Hospital Review Savings	0	0	0	0	0	0	0	0	
d) UR Adjustment	0	0	0	0	0	0	0	0	
e) Disability Legislation	160,000	133,000	0	133,000	107,000	114,000	125,000	134,000	
f) Waiver of Liability Rej	0	(56,000)	0	(56,000)	(58,400)	(60,700)	(62,800)	(64,800)	
g) Freeze Dir. Med. Ed	0	(150,000)	0	(150,000)	(360,000)	(530,000)	(730,000)	(940,000)	
h) PPS Rate Freeze	0	(1,800,000)	0	(1,800,000)	(2,491,000)	(2,548,000)	(2,809,000)	(3,085,000)	
i) Change HHA Reimb.	(5,000)	(70,000)	0	(70,000)	(90,000)	(95,000)	(105,000)	(120,000)	
j) Exempt Hosp. Limit	0	(20,000)	0	(20,000)	(30,000)	(35,000)	(45,000)	(55,000)	
Subtotal, Benefits Current Law	47,906,945	48,313,698	34	48,313,732	52,254,553	57,931,192	64,096,015	70,696,045	
2) PEER REVIEW ORG's	122,055	172,302	(34)	172,268	186,047	201,118	216,185	232,155	249,677
Subtotal Benefit/PRO	48,029,000	48,486,000	0	48,486,000	52,440,600	58,132,300	64,312,200	70,928,200	
3) PMT.SAFEGUARD SAVINGS (Non-Add)*	(646,500)	(615,500)	(378,000)	(993,500)	(1,234,000)	(1,282,300)	(1,330,600)	(1,375,200)	(1,423,000)
4) RESEARCH	3,810	2,518	0	2,518	3,597	3,741	3,879	4,011	4,147
5) ADMINISTRATION									
a) Program Management	327,822	324,824	0	324,824	354,717	378,326	394,089	408,379	423,185
b) SSA	304,393	323,765	0	323,765	330,564	337,175	343,413	349,251	0
c) Other Non-HCFA	36,522	40,804	0	40,804	41,711	39,857	41,227	41,360	0
Subtotal, Administration C.L.	668,737	689,393	0	689,393	726,992	755,358	778,729	798,990	423,185
Subtotal, Admin/Research (4-5)	672,547	691,911	0	691,911	730,589	759,099	782,608	803,000	427,332
Subtotal, Admin.+PRO (2,4-5)	794,602	864,213	(34)	864,179	916,636	960,217	998,793	1,035,155	677,009
6) INTEREST PAYMENT FOR NORMALIZED TAX CREDIT TRANSFER	0	0	0	0	0	0	0	0	0
TOTAL OUTLAYS, CURRENT LAW	48,701,547	49,177,911	0	49,177,911	53,171,189	58,891,399	65,094,808	71,731,200	427,332
TOTAL OUTLAYS, CURRENT LAW, NET OF OFFSETTING RECEIPTS	48,642,547	49,104,911	0	49,104,911	53,085,189	58,796,399	64,988,808	71,614,200	427,332

* Includes MR/UR, Audit and (from FY 1986 on) Medicare Secondary Payer.

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
HI OUTLAYS PROPOSED LAW									
1) BENEFITS									
a) Reduce Indirect ME	0	0	0	0	(695,000)	(1,115,000)	(1,430,000)	(1,595,000)	(1,760,000)
b) Change HHA Reimb.	0	0	0	0	(65,000)	(115,000)	(125,000)	(135,000)	(150,000)
c) Working Aged	0	0	0	0	(230,000)	(350,000)	(400,000)	(440,000)	(490,000)
d) Delay Eligibility	0	0	0	0	(165,000)	(195,000)	(210,000)	(230,000)	(250,000)
e) SNF Limits	0	0	0	0	(5,000)	(5,000)	(5,000)	(5,000)	(5,000)
f) Voucher	0	0	0	0	0	33,000	33,000	33,000	33,000
Subtotal, Benefits Proposed Law	0	0	0	0	(1,160,000)	(1,747,000)	(2,137,000)	(2,372,000)	(2,622,000)
2) ADMINISTRATION									
a) Process on Flow Basis	0	0	0		(3,000)	(4,000)	(4,000)	(4,000)	(5,000)
Subtotal, Administration P.L.	0	0	0	0	(3,000)	(4,000)	(4,000)	(4,000)	(5,000)
TOTAL OUTLAYS, PROPOSED LAW	0	0	0	0	(1,163,000)	(1,751,000)	(2,141,000)	(2,376,000)	(2,627,000)
TOTAL OUTLAYS, PROPOSED LAW, NET OF OFFSETTING RECEIPTS	0	0	0	0	(1,163,000)	(1,751,000)	(2,139,000)	(2,374,000)	(2,624,000)
TOTAL OUTLAYS, NET P.L.	48,701,547	49,177,911	0	49,177,911	52,003,189	57,140,399	62,753,203	69,355,200	(2,199,668)
TOTAL OUTLAYS, NET P.L. AND OFFSETTING RECEIPTS	48,642,547	49,104,911	0	49,104,911	51,922,189	57,045,399	62,849,898	69,240,200	(2,196,668)
END OF YEAR BALANCE									
CURRENT LAW	21,180,615	33,921,704	0	33,921,704	50,092,785	60,536,385	70,063,578	78,899,377	78,462,046
PROPOSED LAW	21,180,615	33,921,704	0	33,921,704	51,362,785	63,717,385	75,763,578	87,700,377	90,601,046

(dollars in thousands)

	FY 1985	* ** ** ** **	FY 1986	* ** ** ** **	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
		REVISED ESTIMATE	CHANGE	CURRENT ESTIMATE					
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE (SMI)									
SMI INCOME, CURRENT LAW									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) Federal Contribution	17,890,000	18,518,000	0	18,518,000	20,198,000	23,506,000	29,023,000	33,825,000	
b) Interest	1,067,000	1,125,000	0	1,125,000	1,006,000	785,000	599,000	598,000	
c) Other	0	0	0	0	0	0	0	0	
TOTAL INCOME W/OUT OFFSETTING RECEIPTS	18,965,000	19,643,000	0	19,643,000	21,204,000	24,291,000	29,622,000	34,423,000	
2)OFFSETTING RECEIPTS									
a) Premiums Aged	4,984,000	5,308,000	0	5,308,000	5,912,000	6,370,000	6,752,000	7,138,000	
b) Premiums Disabled	492,000	513,000	0	513,000	557,000	588,000	614,000	641,000	
c) ESRD TPL Collections	10,000	15,000	0	15,000	20,000	25,000	25,000	25,000	
TOTAL OFFSETTING RECEIPTS	5,486,000	5,836,000	0	5,836,000	6,489,000	6,983,000	7,391,000	7,804,000	
TOTAL INCOME, CURRENT LAW	24,451,000	25,479,000	0	25,479,000	27,693,000	31,274,000	37,013,000	42,227,000	

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
SMI INCOME, PROPOSED LAW									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) Federal Contribution		0	0		(719,000)	(1,449,000)	(2,580,000)	(4,444,000)	(6,486,000)
b) Interest		0	0		17,000	21,000	18,000	20,000	21,000
SUBTOTAL, INCOME W/OUT OFFSETTING RECEIPTS	0	0	0	0	(702,000)	(1,428,000)	(2,562,000)	(4,424,000)	(6,465,000)
2)OFFSETTING RECEIPTS									
a) Premiums Aged	0	0	0	0	202,000	661,000	1,673,000	3,261,000	4,925,000
b) Premiums Disabled	0	0	0	0	19,000	62,000	154,000	296,000	443,000
SUBTOTAL, OFFSETTING RECEIPTS	0	0	0	0	221,000	723,000	1,827,000	3,557,000	5,368,000
TOTAL INCOME, PROPOSED LEGISLATION	0	0	0	0	(481,000)	(705,000)	(735,000)	(867,000)	(1,097,000)
TOTAL INCOME W/OUT OFF RECEIPTS NET PROPOSED LAW	18,965,000	19,643,000	0	19,643,000	20,502,000	22,863,000	27,060,000	29,999,000	(6,465,000)
TOTAL OFF RECEIPTS NET P.L.	5,486,000	5,836,000	0	5,836,000	6,710,000	7,706,000	9,218,000	11,361,000	5,368,000
TOTAL INCOME NET PROPOSED LAW	24,451,000	25,479,000	0	25,479,000	27,212,000	30,569,000	36,278,000	41,360,000	(1,097,000)

(dollars in thousands)

	FY 1985	* ** ** ** **	FY 1986	* ** ** ** **	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
		REVISED ESTIMATE	CHANGE	CURRENT ESTIMATE					
SMI OUTLAYS , CURRENT LAW									
1) BENEFITS									
a) Base	21,376,000	25,481,000	0	25,481,000	28,207,000	31,857,000	35,956,000	40,596,000	
b) Disability Legislation	60,000	55,000	0	55,000	55,000	70,000	65,000	75,000	
c) DME Freeze	0	(50,000)	0	(50,000)	(100,000)	(150,000)	(200,000)	(250,000)	
d) Waiver of Liablity	0	(22,000)	0	(22,000)	(23,000)	(24,000)	(25,000)	(26,000)	
e)	0	0	0	0	0	0	0	0	
Subtotal, Benefits Current Law	21,436,000	25,464,000	0	25,464,000	28,139,000	31,753,000	35,796,000	40,395,000	
2) PEER REVIEW ORGANIZATIONS	0	0	0	8,720	38,635	44,158	49,762	56,386	63,486
Subtotal Benefit/PRO	21,436,000	25,464,000	0	25,472,720	28,177,635	31,797,158	35,845,762	40,451,386	63,486
3) PMT.SAFEGUARD SAVINGS (Non Add)*	(330,800)	(460,200)	(162,000)	(622,200)	(798,000)	(830,000)	(860,900)	(887,700)	(920,800)
4) RESEARCH	7,840	5,182	0	5,182	7,403	7,699	7,984	8,255	8,536
5) ADMINISTRATION									
a) Program Management	782,452	771,168	0	771,168	849,811	914,236	951,760	983,974	1,017,453
DEFRA (Non-Add)	15,000	0	0	0	0	0	0	0	0
b) SSA	201,490	214,209	0	214,209	218,707	223,082	227,209	231,071	580,322
c) Other Non-HCFA	11,474	18,183	0	18,183	19,424	17,842	18,962	18,371	59,731
Subtotal, Administration C.L.	995,416	1,003,560	0	1,003,560	1,087,942	1,155,162	1,197,931	1,233,416	1,657,506
Subtotal, Admin/Research (4-5)	1,003,256	1,008,742	0	1,008,742	1,095,345	1,162,861	1,205,915	1,241,671	1,666,042
Subtotal, Admin.+PRO (2,4-5)	1,003,256	1,008,742	8,720	1,017,462	1,133,980	1,207,019	1,255,677	1,298,057	1,729,528
TOTAL OUTLAYS, CURRENT LAW	22,439,256	26,472,742	8,720	26,481,462	29,272,980	32,960,019	37,051,677	41,693,057	1,729,528
TOTAL OUTLAYS, CURRENT LAW, NET OF OFFSETTING RECEIPTS	16,953,256	20,636,742	8,720	20,645,462	22,783,980	25,977,019	29,660,677	33,899,057	1,729,528

* Includes MR/UR, Audit and (from Fy 1986 on) Medicare Secondary Payer.

(dollars in thousands)

	FY 1985	** ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	** ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	
SMI OUTLAYS PROPOSED LAW										
1) BENEFITS										
a) Physician Fee Freeze Ext.		0	0		(500,000)	(425,000)	(350,000)	(425,000)	(525,000)	
b) Clinical Lab Fee		0	(10,000)	(10,000)	(35,000)	(30,000)	(15,000)	(10,000)	(5,000)	
c) Dynamic Deductible		0	0		0	(50,000)	(100,000)	(175,000)	(275,000)	
d) Working Aged		0	0		(65,000)	(100,000)	(115,000)	(130,000)	(150,000)	
e) Delay Eligibility		0	0		(60,000)	(110,000)	(120,000)	(135,000)	(150,000)	
f) Voucher		0	0		0	17,000	17,000	17,000	17,000	
Subtotal, Benefits Proposed Law	0	0	(10,000)	(10,000)	(660,000)	(698,000)	(683,000)	(858,000)	(1,088,000)	
2) ADMINISTRATION										
a) Elim. RRB Carrier	0	0	0		(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	
Subtotal, Administration P.L.	0	0	0	0	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	
TOTAL OUTLAYS, PROPOSED LAW	0	0	(10,000)	(10,000)	(662,000)	(700,000)	(685,000)	(860,000)	(1,090,000)	
TOTAL OUTLAYS, PROPOSED LAW, NET OF OFFSETTING RECEIPTS	0	0	(10,000)	(10,000)	(893,000)	(1,423,000)	(2,512,000)	(4,417,000)	(6,458,000)	(9,255,000)
TOTAL BENEFIT OUTLAYS, NET P.L.	21,436,000	25,464,000	(10,000)	25,454,000	27,479,000	31,055,000	35,113,000	39,537,000	(1,088,000)	
TOTAL ADMINISTRATION, NET P.L.	1,003,256	1,008,742	0	1,008,742	1,093,345	1,160,861	1,203,915	1,239,671	1,664,042	
TOTAL OUTLAYS, NET P.L.	22,439,256	26,472,742	(10,000)	26,462,742	28,572,345	32,215,861	36,316,915	40,776,671	576,042	
TOTAL OUTLAYS, NET P.L. AND OFFSETTING RECEIPTS	16,953,256	20,636,742	(1,280)	20,635,462	21,900,980	24,554,019	27,148,677	29,472,057	(4,728,472)	
END OF YEAR BALANCE										
CURRENT LAW	10,810,973	9,817,231		9,808,511	8,228,531	6,542,512	6,503,834	7,037,777	5,308,249	
PROPOSED LAW	10,810,973	9,317,231		9,327,231	8,466,886	6,320,025	6,731,107	7,364,438	5,691,376	
BALANCE AS % OF NEXT YEAR'S OUTLAYS										
CURRENT LAW	40.84%	33.54%		26.47%	24.97%	17.66%	15.60%			
PROPOSED LAW	40.34%	34.36%		27.06%	26.28%	18.78%	16.63%			

08-Jul-85 --FY 1987 BUDGET

(dollars in thousands)

	FY 1985	** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
PROGRAM MANAGEMENT - CURRENT SERVICES									
BUDGET AUTHORITY									
1) PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS									
a) Program Level	0	0	0	0	0	0	0	0	
b) Less Hospital Review	0	0	0	0	0	0	0	0	
Subtotal, Obligations	0	0	0	0	0	0	0	0	
c) Less Trust Fund Transfer	0	0	0	0	0	0	0	0	
PSRO B.A.	0	0	0	0	0	0	0	0	
2) RESEARCH									
a) Program Level	34,000	35,462	(13,462)	22,000	22,924	23,841	24,723	25,564	26,433
b) Less Trust Fund Transfer	(11,650)	(12,516)	4,816	(7,700)	(8,023)	(8,344)	(8,653)	(8,947)	(9,251)
RESEARCH B.A.	22,350	22,946	(8,646)	14,300	14,901	15,497	16,070	16,617	17,182
3) MEDICARE CONTRACTORS									
3A) Claims Processing									
a) Program Level	702,100	732,290	(28,690)	703,600	733,151	762,477	790,689	817,572	845,370
b) Less Trust Fund Transfer	(702,100)	(732,290)	28,690	(703,600)	(733,151)	(762,477)	(790,689)	(817,572)	(845,370)
Claims Processing B.A.	0	0	0	0	0	0	0	0	0
3b) Payment Safeguards									
a) Program Level	190,500	198,692	0	209,800	218,612	227,356	235,768	243,784	252,073
b) Less Trust Fund Transfer	(190,500)	(198,692)	0	(209,800)	(218,612)	(227,356)	(235,768)	(243,784)	(252,073)
Payment Safeguards B.A.	0	0	0	0	0	0	0	0	0
3c) Productivity Investments									
a) Program Level	40,000	41,720	(20,120)	21,600	22,507	23,407	24,273	25,097	25,949
b) Less Trust Fund Transfer	(40,000)	(41,720)	20,120	(21,600)	(22,507)	(23,407)	(24,273)	(25,097)	(25,949)
Productivity Investments B.A.	0	0	0	0	0	0	0	0	0
a) Total CONTRACTOR Program Level	932,600	972,702	(37,702)	935,000	974,270	1,013,241	1,050,739	1,086,453	1,123,391
b) Less Total Trust Fund Transfer	(932,600)	(972,702)	37,702	(935,000)	(974,270)	(1,013,241)	(1,050,739)	(1,086,453)	(1,123,391)
TOTAL CONTRACTOR B.A.	0	0	0	0	0	0	0	0	0

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
4) STATE CERTIFICATION									
a) Program Level	49,759	52,147	(2,388)	49,759	52,048	54,338	56,512	58,602	60,771
b) Less Trust Fund Transfer	(47,074)	(50,759)	2,325	(48,434)	(50,662)	(52,891)	(55,007)	(57,042)	(59,152)
STATE CERTIFICATION B.A.	2,685	1,389	(64)	1,325	1,386	1,447	1,505	1,560	1,619
5) ESRD NETWORKS									
a) Program Level	4,837	5,069	(5,069)	0	0	0	0	0	0
b) Less Trust Fund Transfer	(4,837)	(5,069)	5,069	0	0	0	0	0	0
ESRD NETWORK B.A.	0	0	0	0	0	0	0	0	0
6) ADMINISTRATIVE COSTS									
a) Program Level	221,227	225,197	(7,776)	217,421	219,743	222,266	224,615	226,891	229,481
b) Less Trust Fund Transfer	(148,908)	(151,906)	6,234	(145,672)	(148,106)	(149,780)	(151,390)	(152,924)	(154,670)
ADMINISTRATIVE COSTS B.A.	72,319	73,291	(1,542)	71,749	71,637	72,486	73,225	73,967	74,811
TOTAL PROG LEVEL (LESS PSRO HR)	1,242,423	1,290,577	(66,397)	1,224,180	1,268,985	1,313,686	1,356,579	1,397,510	1,440,076
TOTAL TRUST FUND TRANSFER	(1,145,069)	(1,192,952)	56,146	(1,136,806)	(1,181,061)	(1,224,256)	(1,265,780)	(1,305,366)	(1,346,464)
TOTAL PROGRAM MANAGEMENT B.A.	97,354	97,625	(10,251)	87,374	87,924	89,430	90,800	92,144	93,612

GENERAL FUND OUTLAYS	FY 1985	REVISED ESTIMATE	FY 1986 CHANGE	CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
1) RESEARCH	22,350	22,946	(8,646)	14,300	14,901	15,497	16,070	16,617	17,182
2) STATE CERTIFICATION	2,685	1,389	(64)	1,325	1,386	1,447	1,505	1,560	1,619
3) ADMINISTRATIVE COSTS	72,319	73,291	(1,542)	71,749	71,637	72,486	73,225	73,967	74,811
TOTAL PROGRAM MANAGEMENT OUTLAYS	97,354	97,625	(10,252)	87,373	87,924	89,430	90,800	92,144	93,612

(dollars in thousands)

	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
HCFA PROGRAM MANAGEMENT						
o CURRENT SERVICES	97,354	97,625	89,430	90,800	92,144	93,612
o PRESIDENTIAL POLICY	97,354	82,399	99,416	108,544	106,867	104,593
DIFFERENCE	0	15,226	(9,986)	(17,744)	(14,723)	(10,981)
HOSPITAL INSURANCE						
HCFA PROGRAM MANAGEMENT						
o CURRENT SERVICES	331,632	327,342	339,156	354,108	365,113	375,624
o PRESIDENTIAL POLICY	331,632	327,342	359,314	382,067	397,968	412,389
DIFFERENCE	0	0	(20,158)	(27,960)	(32,855)	(36,765)
SUPPLEMENTARY MEDICAL INSURANCE						
HCFA PROGRAM MANAGEMENT						
o CURRENT SERVICES	790,292	776,350	824,420	851,663	882,182	911,311
o PRESIDENTIAL POLICY	790,292	776,350	857,214	921,937	959,744	992,229
DIFFERENCE	0	0	(32,794)	(70,273)	(77,562)	(80,918)

(dollars in thousands)

	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
CURRENT SERVICES						
TOTAL BUDGET AUTHORITY						
1) MEDICAID	21,845,491	24,384,815	25,907,488	28,642,300	31,347,800	34,331,200
2) PROGRAM MANAGEMENT	97,354	97,625	87,924	87,410	90,300	92,144
3) HOSPITAL INSURANCE	52,645,000	61,965,000	69,234,270	69,014,000	74,153,000	79,887,000
4) SUPPLEMENTARY MEDICAL INSURANCE	24,450,000	25,588,000	27,793,000	31,418,000	37,231,000	42,533,000
TOTAL BUDGET AUTHORITY	103,099,842	116,292,925	128,462,994	134,852,630	111,474,800	122,512,144
TOTAL OUTLAYS						
1) MEDICAID	22,812,753	24,414,100	25,907,488	28,642,300	31,347,800	34,331,200
2) PROGRAM MANAGEMENT	97,354	97,625	87,430	90,200	92,144	93,612
3) HOSPITAL INSURANCE	48,706,547	51,258,332	56,165,271	62,120,154	68,891,673	75,948,242
4) SUPPLEMENTARY MEDICAL INSURANCE	22,439,256	26,529,665	29,398,538	33,005,461	37,134,403	41,817,681
TOTAL OUTLAYS	94,055,910	102,299,723	111,470,726	123,858,715	137,376,020	152,190,734

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
FEDERAL HOSPITAL INSURANCE (HI)									
HI INCOME, CURRENT SERVICES									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) FICA	39,166,000	43,527,000	0	43,527,000	47,962,000	52,454,000	56,699,000	61,375,000	
b) SECA	1,933,000	2,292,000	0	2,292,000	2,465,000	2,800,000	3,013,000	3,357,000	
c) Refunds	(110,000)	(124,000)	0	(124,000)	(148,000)	(171,000)	(190,000)	(212,000)	
d) Deposits by States	4,308,000	5,002,000	0	5,002,000	5,436,000	5,792,000	6,016,000	6,570,000	
e) RRB Transfer	321,000	336,000	0	336,000	364,000	378,000	384,000	389,000	
f) Fed Employer Contrib	1,269,000	1,407,000	0	1,407,000	1,521,000	1,624,000	1,724,000	1,864,000	
g) Fed Employer Contrib (Postal)	186,000	207,000	0	207,000	221,000	234,000	243,000	256,000	
h) General Fund Transfer	1,348,000	1,076,000	0	1,076,000	1,150,000	1,117,000	1,093,000	923,000	
i) Interest	2,090,000	2,707,000	0	2,707,000	3,779,000	4,639,000	5,014,000	5,214,000	
j) RRB Interest	47,000	43,000	0	43,000	42,000	37,000	27,000	22,000	
k) OASI Repayment	1,824,000	4,609,000	0	4,609,000	6,013,270	0	0	0	
l) Interest from OASI	1,206,000	811,000	0	811,000	215,000	0	0	0	
m) Interest on Overpayments	8,000	8,000	0	8,000	8,000	8,000	8,000	8,000	
TOTAL INCOME W/OUT OFFSETTING RECEIPTS	52,586,000	61,892,000	0	61,892,000	69,148,270	68,916,000	74,043,000	79,766,000	
2)OFFSETTING RECEIPTS									
a) Premiums Collected	44,000	53,000	0	53,000	61,000	68,000	75,000	81,000	
b) ESRD TPL Collections	15,000	20,000	0	20,000	25,000	30,000	35,000	40,000	
TOTAL OFFSETTING RECEIPTS	59,000	73,000	0	73,000	86,000	98,000	110,000	121,000	
TOTAL INCOME, CURRENT SERVICES	52,645,000	61,965,000	0	61,965,000	69,234,270	69,014,000	74,153,000	79,887,000	

(dollars in thousands)

FEDERAL SUPPLEMENTARY MEDICAL INSURANCE (SMI)

SMI INCOME, CURRENT SERVICES

	FY 1985	** ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	** ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) Federal Contribution	17,898,000	18,601,000	0	18,601,000	20,257,000	23,613,000	29,207,000	34,094,000	
b) Interest	1,066,000	1,124,000	0	1,124,000	1,007,000	784,000	595,000	594,000	
c) Other	0	0	0	0	0	0	0	0	
TOTAL INCOME W/OUT OFFSETTING RECEIPTS	18,964,000	19,725,000	0	19,725,000	21,266,000	24,397,000	29,802,000	34,689,000	
2)OFFSETTING RECEIPTS									
a) Premiums Aged	4,984,000	5,333,000	0	5,333,000	5,946,000	6,405,000	6,787,000	7,175,000	
b) Premiums Disabled	492,000	515,000	0	515,000	561,000	591,000	617,000	645,000	
c) ESRD TPL Collections	10,000	15,000	0	15,000	20,000	25,000	25,000	25,000	
TOTAL OFFSETTING RECEIPTS	5,486,000	5,863,000	0	5,863,000	6,527,000	7,021,000	7,429,000	7,845,000	
TOTAL INCOME, CURRENT SERVICES	24,450,000	25,588,000	0	25,588,000	27,793,000	31,418,000	37,231,000	42,533,000	

(dollars in thousands)

	FY 1985	** ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	** ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
PAYMENTS TO HEALTH CARE TRUST FUNDS									
B.A./OUTLAYS, CURRENT SERVICES									
1) MILITARY SERVICE CREDITS	86,000	91,000	0	91,000	92,000	94,000	95,000	96,000	
2) HI FOR THE UNINSURED	762,000	554,000	0	554,000	601,000	563,000	525,000	434,000	
3) HI FOR UNINSURED FEDERAL			0						
ANNUITANTS AND EMPLOYEES	4,000	12,000	0	12,000	14,000	17,000	18,000	18,000	
4) FEDERAL CONTRIBUTION FOR SMI	17,898,000	18,601,000	0	18,601,000	20,257,000	23,613,000	29,207,000	34,094,000	
SUBTOTAL, APPROPRIATION C.S.	18,750,000	19,258,000	0	19,258,000	20,964,000	24,287,000	29,845,000	34,692,000	
5) SECA CREDITS *	496,000	419,000	0	419,000	423,000	445,000	460,000	325,000	
TOTAL B.A., CURRENT SERVICES	19,246,000	19,677,000	0	19,677,000	21,387,000	24,732,000	30,305,000	35,017,000	
TOTAL OUTLAYS, CURRENT SERVICES	19,246,000	19,677,000	0	19,677,000	21,387,000	24,732,000	30,305,000	35,017,000	

* FY 1985 estimate includes $459,000 of permanent appropriation for that year, plus $52,000 carryover from FY 1984.

08-Jul-85 --FY 1987 BUDGET

(dollars in thousands)

HCFA DIVISION OF BUDGET

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
HI OUTLAYS , CURRENT SERVICES									
1) BENEFITS									
a) Base *	47,751,945	50,276,698	34	50,276,732	55,176,953	61,085,892	67,722,815	74,826,845	
b) Hospital Reviews	0	0	0	0	0	0	0	0	
c) Hospital Review Savings	0	0	0	0	0	0	0	0	
d) UR Adjustment	0	0	0	0	0	0	0	0	
e) Disability Legislation	160,000	133,000	0	133,000	107,000	114,000	125,000	134,000	
Subtotal, Benefits Current Law	47,911,945	50,409,698	34	50,409,732	55,283,953	61,199,892	67,847,815	74,960,845	
2) PEER REVIEW ORG's	122,055	172,302	(34)	172,268	186,047	201,113	216,185	232,155	249,677
Subtotal Benefits/PRO	48,034,000	50,582,000	0	50,582,000	55,470,000	61,401,000	68,064,000	75,193,000	
3) PMT. SAFEGUARD SAVING (Non-Add)	(646,500)	(615,500)	(378,000)	(993,500)	(1,234,000)	(1,282,300)	(1,330,600)	(1,375,200)	(1,423,000)
4) RESEARCH	3,810	2,518	0	2,518	2,623	2,729	2,829	2,925	3,025
5) ADMINISTRATION									
a) Program Management	327,822	324,824	0	324,824	335,533	351,379	362,283	372,699	383,413
b) SSA	304,393	311,090	0	311,090	317,623	323,975	329,969	335,578	
c) Other Non-HCFA	36,522	37,900	0	37,900	39,492	41,072	42,591	44,039	
Subtotal, Administration C.S.	668,737	673,815	0	673,815	692,648	716,426	734,844	752,316	
Subtotal, Admin/Research (4-5)	672,547	676,332	0	676,332	695,271	719,154	737,673	755,242	
Subtotal, Admin.+PRO (2,4-5)	794,602	848,634	(34)	848,600	881,318	920,272	953,858	987,397	
6) INTEREST PAYMENT FOR NORMALIZED TAX CREDIT TRANSFER	0	0	0	0	0	0	0	0	
TOTAL OUTLAYS, CURRENT SERVICES	48,706,547	51,258,332	0	51,258,332	56,165,271	62,120,154	68,801,673	75,948,242	
TOTAL OUTLAYS, CUR. SERV., NET OF OFFSETTING RECEIPTS	48,647,547	51,185,332	0	51,185,332	56,079,271	62,022,154	68,691,673	75,827,242	

(dollars in thousands)

	FY 1985	* ** ** ** ** REVISED ESTIMATE	FY 1986 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
SMI OUTLAYS , CURRENT SERVICES									
1) BENEFITS									
a) Base	21,376,000	25,481,000	0	25,481,000	28,207,000	31,657,000	35,956,000	40,596,000	
b) Disability Legislation	60,000	55,000	0	55,000	55,000	70,000	65,000	75,000	
Subtotal, Benefits Current Law	21,436,000	25,536,000	0	25,536,000	28,262,000	31,727,000	36,021,000	40,671,000	
2) PEER REVIEW ORGANIZATIONS	0	0	0	8,720	39,635	44,158	49,762	56,386	
Subtotal Benefit/PRO	21,436,000	25,536,000	0	25,544,720	28,300,615	31,771,158	36,070,762	40,727,386	0
2) PMT. SAFEGUARD SAVINGS (Non-Add)	(330,800)	(460,200)	(162,000)	(622,200)	(798,000)	(830,000)	(860,900)	(889,900)	(920,800)
3) RESEARCH	7,840	5,182	0	5,182	5,400	5,615	5,824	6,022	6,226
4) ADMINISTRATION									
a) Program Management	782,452	771,168	0	771,168	819,020	846,048	876,359	905,289	934,743
DEFRA (NON-ADD)	15,000	0	0	0	0	0	0	0	
b) SSA	201,490	205,923	0	205,923	210,247	214,452	218,419	222,133	
c) Other Non-HCFA	11,474	11,392	0	11,392	11,870	12,345	12,802	13,237	
Subtotal, Administration C.S.	995,416	988,483	0	988,483	1,041,138	1,072,845	1,107,580	1,140,660	
Subtotal, Admin/Research	1,003,256	993,665	0	993,665	1,046,538	1,078,461	1,113,403	1,146,681	
TOTAL OUTLAYS, CURRENT SERVICES	22,439,256	26,529,665	0	26,529,665	29,308,538	33,005,461	37,134,403	41,317,681	
TOTAL OUTLAYS, CUR. SERV., NET OF OFFSETTING RECEIPTS	16,953,256	20,666,665	0	20,666,665	22,781,538	25,984,461	29,705,403	41,817,681	

CURRENT SERVICES GRANTS TO STATES FOR MEDICAID	FY 1985	# ## ## ## ## REVISED ESTIMATE	FY 1986 CHANGE	# ## ## ## ## CURRENT ESTIMATE	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	
1) MEDICAL ASSISTANCE PAYMENTS										
a) State Estimates (11/84)	21,693,397	24,044,096	(154,195)	23,889,901	25,714,596	28,558,000	31,365,000	34,402,000		
Adjustments	(300,000)	(760,000)	0	(760,000)	(855,000)	(950,000)	(1,045,000)	(1,140,000)		
	21,393,387	23,284,096	(154,195)	23,129,901	24,859,596	27,608,000	30,320,000	33,262,000		
b) Impact of Dis./Ch. Supp./OBRA	122,047	45,000	0	45,000	50,000	55,000	5,000	0		
c) TPL from Child Support	0	0	0	0	0	0	0	0		
d) Michel & 133	(53,000)	0	0	0	0	0	0	0		
d) OBRA	345,348	0	0	0	0	0	0	0		
e) Financial Adjustments	(210,000)	0	0	0	0	0	0	0		
d) Regulatory Impact	0	0	0	0	0	0	0	0		
e) Prior Year Claims	0	0	0	0	0	0	0	0		
SUBTOTAL, MEDICAL ASSISTANCE	21,597,782	23,329,096	(154,195)	23,174,901	24,909,596	27,663,000	30,325,000	33,262,000		
SUBTOTAL,OBL.WHERE DIFF.FROM OUT.										
2) STATE AND LOCAL ADMINISTRATION										1,412,000
a) State Estimates (11/84)	1,167,664	1,191,988	55,210	1,247,198	1,305,138	1,362,600	1,417,000	1,469,500		
b) Regulatory Impact	0	0	0	0	0	0	0	0		
c) OBRA	19,203	0	0	0	0	0	0	0		
d) Financial & Other Adjustments	(2,047)	(40,000)	0	(40,000)	(45,000)	(50,000)	(55,000)	(60,000)		
SUBTOTAL, S&L ADMINISTRATION	1,184,820	1,151,988	55,210	1,207,198	1,260,138	1,312,600	1,362,000	1,409,500		
3) STATE CERTIFICATION										
a) State Estimates (11/84)	39,610	46,785	0	46,785	49,000	51,000	53,000	55,000		
b) OBRA	0	0	0	0	0	0	0	0		
c) Financial Adjustments	0	0	0	0	0	0	0	0		
SUBTOTAL, STATE CERTIFICATION	39,610	46,785	0	46,785	49,000	51,000	53,000	55,000		
4) FRAUD CONTROL UNITS	28,494	42,931	0	42,931	45,000	47,000	49,000	51,000		
SUBTOTAL, ALL ADMIN (2-4). OUT.	1,252,924	1,241,704	55,210	1,296,914	1,354,138	1,410,600	1,464,000	1,515,500		
SUBTOTAL,OBL.WHERE DIFF.FROM OUT.										
TOTAL OBLIGATIONS/OUTLAYS C.L.	22,850,706	24,570,800	(98,985)	24,471,815	26,263,734	29,073,600	31,789,000	34,777,500		
TOTAL OBL.WHERE DIFF.FROM OUT.										
UNOBLIGATED BALANCE										
o Start of Year	(1,017,064)	(60,676)	0	(60,676)	0	0	0	0		
o End of Year	171,049	0	0	0	0	0	0	0		
o Prior Year Claims	(122,047)									
APPROPRIATION/ BA	21,845,491	24,510,124	(98,985)	24,411,139	26,263,734	29,073,600	31,789,000	34,777,500		
o Advanced Appropriation	5,552,000	5,980,000	0	5,980,000	6,500,000	7,100,000	7,800,000	8,500,000		
o Remaining Appropriation	16,293,491	18,530,124	(98,985)	18,431,139	19,763,734	21,973,600	23,989,000	26,277,500		

(dollars in thousands)

CROSSWALK TABLE PRESIDENTIAL POLICY

	FY 1985			FY 1986			FY 1987			FY 1988		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
OBLIGATIONS												
1)RESEARCH	3,810	7,840	11,650	2,518	5,182	7,700	3,597	7,403	11,000	3,741	7,699	11,440
ADMINISTRATIVE ACTIVITIES												
1)PSRO	0	0	(0)	0	0	(0)	0	0	(0)	0	0	(0)
2)CLAIMS PROCESSING	158,468	539,632	698,100	151,312	532,288	683,600	174,974	595,926	770,900	191,052	650,588	841,640
3)PAYMENT SAFEGUARDS	43,244	147,257	190,500	47,625	162,175	209,800	49,690	169,210	218,900	51,678	175,978	227,656
4)PRODUCTIVITY INVESTMENTS	9,280	30,720	40,000	4,903	16,697	21,600	6,265	21,335	27,600	6,516	22,188	28,704
5)STATE CERTIFICATION	31,775	15,299	47,074	32,693	15,741	48,434	38,167	18,377	56,544	42,581	20,502	63,083
6)ESRD NETWORKS	256	4,581	4,837	0	0	(0)		0	(0)	0	0	(0)
7)ADMINISTRATIVE COSTS	89,345	59,563	148,908	87,403	58,269	145,672	90,013	60,008	150,021	91,131	60,754	151,885
TOTAL, ADMIN ACTIVITIES	332,168	797,251	1,129,419	328,936	785,170	1,114,106	359,130	864,835	1,223,965	382,958	930,010	1,312,968
TOTAL, RESEARCH/ADMIN	335,978	805,091	1,141,069	331,454	790,352	1,121,806	362,726	872,239	1,234,965	386,699	937,709	1,324,408
SOCIAL SECURITY ADMINISTRATION	297,690	207,078	504,768	329,586	218,059	547,645	337,310	223,170	560,480	334,056	227,635	561,691
OTHER NON-HCFA ADMINISTRATION												
1)TREASURY	18,667	3,217	21,884	28,864	2,472	31,336	29,771	3,708	33,479	27,917	2,118	30,035
2)RAILROAD RETIREMENT BOARD	0	1,209	1,209	0	1,209	1,209	0	1,209	1,209	0	1,209	1,209
3)DEPARTMENT MANGEMENT	4,592	1,680	6,272	1,216	1,824	3,040	1,216	1,824	3,040	1,216	1,824	3,040
4)CIVIL RIGHTS	1,904	212	2,116	3,901	0	3,901	3,901	0	3,901	3,901	0	3,901
5)INSPECTOR GENERAL	1,140	4,600	5,740	3,900	12,000	15,900	3,900	12,000	15,900	3,900	12,000	15,900
6)OPM	0	72	72	0	74	74	0	77	77	0	37	37
7)PUBLIC HEALTH SERVICE	898	120	1,018	180	120	300	180	120	300	180	120	300
8)PROSPECTIVE PAYMENT COMMISSION	1,275	364	1,639	2,743	484	3,227	2,743	484	3,227	2,743	484	3,227
SUBTOTAL, OTHER NON-HCFA ADMIN.	28,476	11,474	39,950	40,804	18,183	58,987	41,711	19,424	61,135	39,857	17,792	57,649
TOTAL NON-HCFA ADMINISTRATION	326,166	218,552	544,718	370,390	236,242	606,632	379,021	242,594	621,615	373,913	245,427	619,340
TOTAL OBLIGATIONS	662,144	1,023,643	1,685,787	701,844	1,026,594	1,728,438	741,747	1,114,833	1,856,580	760,612	1,183,136	1,943,748

(dollars in thousands)

CROSSWALK TABLE PRESIDENTIAL POLICY

	FY 1985			FY 1986			FY 1987			FY 1988		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
OUTLAYS												
1)RESEARCH	3,810	7,840	11,650	2,518	5,182	7,700	3,597	7,403	11,000	3,741	7,699	11,440
ADMINISTRATIVE ACTIVITIES												
1)PSRO	0	0	0	0	0	0	0	0	0	0	0	0
2)CLAIMS PROCESSING	154,122	524,833	678,955	152,200	518,286	670,486	170,532	580,931	751,463	186,421	634,816	821,236
3)PAYMENT SAFEGUARDS	43,244	147,257	190,500	47,625	162,175	209,800	49,690	169,210	218,900	51,678	175,978	227,656
4)PRODUCTIVITY INVESTMENTS	9,080	30,920	40,000	4,903	16,697	21,600	6,265	21,335	27,600	6,516	22,188	28,704
5)STATE CERTIFICATION	31,775	15,299	47,074	32,693	15,741	48,434	38,167	18,377	56,544	42,581	20,502	63,083
6)ESRD NETWORKS	256	4,581	4,837	0	0	0	0	0	0	0	0	0
7)ADMINISTRATIVE COSTS	89,345	59,563	148,908	87,403	58,269	145,672	90,013	60,008	150,021	91,131	60,754	151,885
TOTAL, ADMIN ACTIVITIES	327,822	782,452	1,110,274	324,824	771,168	1,095,992	354,717	849,811	1,204,528	378,326	914,238	1,292,564
TOTAL, RESEARCH/ADMIN	331,632	790,292	1,121,924	327,342	776,350	1,103,692	358,314	857,214	1,215,528	382,067	921,937	1,304,004
SOCIAL SECURITY ADMINISTRATION	394,393	201,490	595,883	323,765	214,209	537,974	330,564	218,707	549,271	337,175	223,082	560,257
OTHER NON HCFA ADMINISTRATION	36,522	11,474	47,996	40,804	18,183	58,987	41,711	19,424	61,135	39,857	17,842	57,699
TOTAL NON-HCFA ADMINISTRATION	340,915	212,964	553,879	364,569	232,392	596,961	372,275	238,131	610,406	377,032	240,924	617,956
TOTAL OUTLAYS	672,547	1,003,256	1,675,803	691,911	1,008,742	1,700,653	730,589	1,095,345	1,825,934	759,099	1,162,861	1,921,960

(dollars in thousands)

CROSSWALK TABLE - CURRENT SERVICES

	FY 1985			FY 1986			FY 1987			FY 1988		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
OBLIGATIONS												
1)RESEARCH	3,810	7,840	11,650	2,518	5,182	7,700	2,623	5,400	8,023	2,729	5,615	8,344
ADMINISTRATIVE ACTIVITIES												
1)PSRO	0	0	(0)	0	0	(0)	0	0	(0)	0	0	(0)
2)CLAIMS PROCESSING	158,468	539,632	678,100	156,312	532,288	688,600	166,425	566,726	733,151	173,082	589,395	762,477
3)PAYMENT SAFEGUARDS	43,244	147,257	190,500	47,625	162,175	209,800	49,625	168,987	218,612	51,610	175,746	227,356
4)PRODUCTIVITY INVESTMENTS	9,080	30,920	40,000	4,903	16,697	21,600	5,109	17,398	22,507	5,313	18,094	23,407
5)STATE CERTIFICATION	31,775	15,299	47,074	32,693	15,741	48,434	34,197	16,465	50,662	35,701	17,190	52,891
6)ESRD NETWORKS	256	4,581	4,837	0	0	(0)	0	0	(0)	0	0	(0)
7)ADMINISTRATIVE COSTS	89,345	59,563	148,908	87,403	58,269	145,672	88,864	59,242	148,106	89,868	59,912	149,780
	0											
TOTAL, ADMIN ACTIVITIES	332,168	797,251	1,129,419	328,936	785,170	1,114,106	344,220	828,818	1,173,038	355,575	860,337	1,215,912
TOTAL, RESEARCH/ADMIN	335,978	805,091	1,141,069	331,454	790,352	1,121,806	346,843	834,218	1,181,061	358,304	865,952	1,224,256
SOCIAL SECURITY ADMINISTRATION	312,834	207,078	504,768	316,792	209,698	526,490	324,105	214,538	538,643	330,587	218,829	549,416
OTHER NON-HCFA ADMINISTRATION												
1)TREASURY	27,058	3,217	31,884	28,249	3,359	31,607	29,435	3,500	32,935	30,612	3,640	34,252
2)RAILROAD RETIREMENT BOARD	0	1,209	1,209	0	1,262	1,262	0	1,315	1,315	0	1,368	1,368
3)DEPARTMENT MANGEMENT	1,520	1,680	6,272	1,587	1,754	3,341	1,654	1,828	3,481	1,720	1,901	3,620
4)CIVIL RIGHTS	1,904	212	2,116	1,988	221	2,209	2,071	231	2,302	2,154	240	2,394
5)INSPECTOR GENERAL	3,000	4,609	5,740	3,967	4,802	8,770	4,134	5,004	9,138	4,299	5,204	9,503
6)CPR	0	72	72	0	75	75	0	78	78	0	81	81
7)PUBLIC HEALTH SERVICE	100	120	1,018	188	125	313	196	131	326	204	136	339
8)PROSPECTIVE PAYMENT COMMISSION	2,060	364	1,639	2,151	380	2,531	2,241	396	2,637	2,331	412	2,742
SUBTOTAL, OTHER NON-HCFA ADMIN.	36,522	11,474	39,950	38,129	11,979	50,108	39,730	12,482	52,212	41,320	12,981	54,301
TOTAL NON-HCFA ADMINISTRATION	349,358	218,552	544,718	354,921	221,677	576,598	363,835	227,020	590,855	371,907	231,810	603,717
TOTAL OBLIGATIONS	665,336	1,023,643	1,685,787	686,375	1,012,029	1,698,404	710,678	1,061,238	1,771,916	730,210	1,097,762	1,827,973

(dollars in thousands)

CROSSWALK TABLE CURRENT SERVICES

	FY 1985			FY 1986			FY 1987			FY 1988		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
OUTLAYS												
1)RESEARCH	3,810	7,840	11,650	2,518	5,182	7,700	2,623	5,400	8,023	2,729	5,615	8,344
ADMINISTRATIVE ACTIVITIES												
1)PSRO	0	0	0	0	0	0	0	0	0	0	0	0
2)CLAIMS PROCESSING	154,122	524,833	678,955	152,200	518,286	670,486	162,229	552,437	714,666	168,887	575,126	743,973
3)PAYMENT SAFEGUARDS	43,244	147,257	190,501	47,625	162,175	209,800	49,625	168,987	218,612	51,610	175,746	227,356
4)PRODUCTIVITY INVESTMENTS	9,080	30,920	40,000	4,903	16,697	21,600	5,109	17,398	22,507	5,313	18,074	23,407
5)STATE CERTIFICATION	31,775	15,299	47,074	32,693	15,741	48,434	34,197	16,465	50,662	35,701	17,190	52,891
6)ESPO NETWORKS	256	4,581	4,837	0	0	0	(4,491)	4,491	0	0	0	0
7)ADMINISTRATIVE COSTS	89,345	59,563	148,908	87,403	58,269	145,672	88,864	59,242	148,106	89,868	59,912	149,780
TOTAL, ADMIN ACTIVITIES	327,822	782,452	1,110,274	324,824	771,168	1,095,992	335,533	819,020	1,154,553	351,379	846,048	1,197,427
TOTAL, RESEARCH/ADMIN	331,632	790,292	1,121,924	327,342	776,350	1,103,692	338,156	824,420	1,162,576	354,108	851,663	1,205,771
SOCIAL SECURITY ADMINISTRATION	304,393	201,490	505,883	311,090	205,923	517,013	317,623	210,247	527,870	323,975	214,452	538,427
OTHER NON-HCFA ADMINISTRATION	36,522	11,474	47,996	37,900	11,392	49,292	39,492	11,870	51,362	41,072	12,345	53,417
TOTAL NON-HCFA ADMINISTRATION	340,915	212,964	553,879	348,990	217,315	566,305	357,115	222,117	579,232	365,047	226,797	591,844
TOTAL OUTLAYS	672,547	1,003,256	1,675,803	676,332	993,665	1,669,997	695,271	1,046,538	1,741,809	719,154	1,078,461	1,797,615

(dollars in thousands)

PRESIDENTIAL POLICY	FY 1989			FY 1990			FY 1991		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
OBLIGATIONS									
1)RESEARCH	3,879	7,984	11,863	4,011	8,255	12,266	4,147	8,536	12,683
ADMINISTRATIVE ACTIVITIES									
1)PSRO	0	0	(0)	0	0	(0)	0	0	(0)
2)CLAIMS PROCESSING	199,091	677,964	877,055	205,620	700,196	905,816	212,601	723,969	936,570
3)PAYMENT SAFEGUARDS	53,590	182,489	236,079	55,412	188,694	244,106	57,296	195,110	252,406
4)PRODUCTIVITY INVESTMENTS	6,757	23,009	29,766	6,987	23,791	30,778	7,224	24,600	31,824
5)STATE CERTIFICATION	47,098	22,677	69,775	51,764	24,923	76,687	56,564	27,235	83,799
6)ESRD NETWORKS	0	0	(0)	0	0	(0)	0	0	(0)
7)ADMINISTRATIVE COSTS	92,207	61,471	153,678	93,232	62,154	155,386	94,292	62,861	157,153
TOTAL, ADMIN ACTIVITIES	398,743	967,610	1,366,353	413,014	999,759	1,412,773	427,978	1,033,774	1,461,752
TOTAL, RESEARCH/ADMIN	402,622	975,594	1,378,216	417,025	1,008,014	1,425,039	432,125	1,042,310	1,474,435
SOCIAL SECURITY ADMINISTRATION	350,421	321,846	672,267	356,379	235,787	592,166	356,379	235,787	592,166
OTHER NON-HCFA ADMINISTRATION									
1)TREASURY	29,287	3,223	32,510	29,420	2,609	32,028			
2)RAILROAD RETIREMENT BOARD	0	1,207	1,207	0	1,207	1,207			
3)DEPARTMENT MANGEMENT	1,216	1,824	3,040	1,216	1,824	3,040			
4)CIVIL RIGHTS	3,901	0	3,901	3,901	0	3,901			
5)INSPECTOR GENERAL	3,900	12,000	15,900	3,900	12,000	15,900			
6)OPM	0	102	102	0	126	126			
7)PUBLIC HEALTH SERVICE	180	120	300	180	120	300			
8)PROSPECTIVE PAYMENT COMMISSION	2,743	484	3,227	2,743	484	3,227			
SUBTOTAL, OTHER NON-HCFA ADMIN.	41,227	18,962	60,187	41,360	18,371	59,731			
TOTAL NON-HCFA ADMINISTRATION	391,648	340,808	732,456	397,739	254,158	651,897			
TOTAL OBLIGATIONS	794,270	1,316,402	2,110,672	814,764	1,262,172	2,076,936			

(dollars in thousands)

PRESIDENTIAL POLICY

	FY 1989			FY 1990			FY 1991		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
OUTLAYS									
1)RESEARCH	3,879	7,984	11,863	4,011	8,255	12,266	4,147	8,536	12,683
ADMINISTRATIVE ACTIVITIES									
1)PSRO	0	0	0	0	0	0	0	0	0
2)CLAIMS PROCESSING	194,437	662,114	856,551	200,985	684,411	885,395	207,809	707,647	915,456
3)PAYMENT SAFEGUARDS	53,590	182,489	236,079	55,412	188,694	244,106	57,296	195,110	252,406
4)PRODUCTIVITY INVESTMENTS	6,757	23,009	29,766	6,987	23,791	30,778	7,224	24,600	31,824
5)STATE CERTIFICATION	47,098	22,677	69,775	51,764	24,923	76,687	56,564	27,235	83,799
6)ESRD NETWORKS	0	0	0	0	0	0	0	0	0
ISTRATIVE COSTS	92,207	61,471	153,678	93,232	62,154	155,386	94,292	62,861	157,153
TOTAL ADMIN ACTIVITIES	394,089	951,760	1,345,849	408,379	983,974	1,392,352	423,185	1,017,453	1,440,638
TOTAL, RESEARCH/ADMIN	397,968	959,744	1,357,712	412,389	992,229	1,404,618	427,332	1,025,989	1,453,321
SOCIAL SECURITY ADMINISTRATION	343,413	227,209	570,622	349,251	231,071	580,322			
OTHER NON-HCFA ADMINISTRATION	41,227	18,962	60,189	41,360	18,371	59,731			
TOTAL NON-HCFA ADMINISTRATION	384,640	246,171	630,811	390,611	249,442	640,053			
TOTAL OUTLAYS	782,608	1,205,915	1,988,523	803,000	1,241,671	2,044,671			

(dollars in thousands)

CURRENT SERVICES

	FY 1989			FY 1990			FY 1991		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
OBLIGATIONS									
1)RESEARCH	2,829	5,824	8,653	2,925	6,022	8,947	3,025	6,226	9,251
ADMINISTRATIVE ACTIVITIES									
1)PSRO	0	0	(0)	0	0	(0)	0	0	(0)
2)CLAIMS PROCESSING	179,486	611,203	790,689	185,589	631,983	817,572	192,899	653,471	846,370
3)PAYMENT SAFEGUARDS	53,519	182,249	235,768	55,339	188,445	243,784	57,221	194,852	252,073
4)PRODUCTIVITY INVESTMENTS	5,510	18,763	24,273	5,697	19,400	25,097	5,890	20,059	25,949
5)STATE CERTIFICATION	37,130	17,877	55,007	38,503	18,539	57,042	38,928	19,224	58,152
6)ESRD NETWORKS	0	0	(0)	0	0	(0)	0	0	(0)
7)ADMINISTRATIVE COSTS	90,834	60,556	151,390	91,754	61,170	152,924	92,802	61,868	154,670
TOTAL, ADMIN ACTIVITIES	366,479	890,647	1,257,127	376,883	919,537	1,296,420	387,740	949,474	1,337,214
TOTAL, RESEARCH/ADMIN	369,307	896,471	1,265,780	379,808	925,558	1,305,367	390,764	955,701	1,346,465
SOCIAL SECURITY ADMINISTRATION	336,703	222,877	559,580	342,427	226,666	569,093			
OTHER NON-HCFA ADMINISTRATION									
1)TREASURY	31,745	3,774	35,519	32,824	3,903	36,727			
2)RAILROAD RETIREMENT BOARD	0	1,413	1,413	0	1,467	1,467			
3)DEPARTMENT MANGEMENT	1,783	1,971	3,754	1,844	2,038	3,882			
4)CIVIL RIGHTS	2,234	249	2,483	2,310	257	2,567			
5)INSPECTOR GENERAL	4,458	5,397	9,855	4,610	5,580	10,190			
6)OPM	0	84	84	0	87	87			
7)PUBLIC HEALTH SERVICE	211	141	352	218	146	364			
8)PROSPECTIVE PAYMENT COMMISSION	2,417	427	2,844	2,499	442	2,941			
SUBTOTAL, OTHER NON-HCFA ADMIN.	42,848	13,462	56,310	44,305	13,919	58,225			
TOTAL NON-HCFA ADMINISTRATION	379,551	236,339	615,890	386,732	240,585	627,318			
TOTAL OBLIGATIONS	748,860	1,132,810	1,881,670	766,540	1,166,144	1,932,684			

(dollars in thousands)

CURRENT SERVICES	FY 1989			FY 1990			FY 1991		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
OUTLAYS									
1)RESEARCH	2,829	5,824	8,653	2,925	6,022	8,947	3,025	6,226	9,251
ADMINISTRATIVE ACTIVITIES									
1)PSRO	0	0	0	0	0	0	0	0	0
2)CLAIMS PROCESSING	175,290	596,914	772,204	181,405	617,736	799,141	187,573	638,739	826,312
3)PAYMENT SAFEGUARDS	53,519	182,249	235,768	55,339	188,445	243,784	57,221	194,852	252,073
4)PRODUCTIVITY INVESTMENTS	5,510	18,763	24,273	5,677	19,400	25,077	5,890	20,059	25,949
5)STATE CERTIFICATION	37,130	17,877	55,007	39,503	18,539	57,042	39,928	19,224	59,152
6)ESRD NETWORKS	0	0	0	0	0	0	0	0	0
7)ADMINISTRATIVE COSTS	90,834	60,556	151,390	91,754	61,170	152,924	92,802	61,868	154,670
TOTAL, ADMIN ACTIVITIES	362,283	876,359	1,238,642	372,699	905,289	1,277,988	383,413	934,743	1,318,156
TOTAL, RESEARCH/ADMIN	365,113	882,182	1,247,295	375,624	911,311	1,286,935	386,438	940,969	1,327,407
SOCIAL SECURITY ADMINISTRATION	329,969	218,419	548,388	335,578	222,133	557,711			
OTHER NON-HCFA ADMINISTRATION	42,591	12,802	55,393	44,039	13,237	57,277			
TOTAL NON-HCFA ADMINISTRATION	372,560	231,221	603,781	379,617	235,370	614,988			
TOTAL OUTLAYS	737,673	1,113,403	1,851,076	755,242	1,146,681	1,901,923			

TRUST FUND TRANSFER PERCENTAGES

	FY 1984	FY 85 OLD	FY 85 NEW	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
PSRO	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
RESEARCH	37.7643%	34.2857%	35.2941%	35.2941%	35.2941%	35.2956%	35.2961%	35.2965%	35.2965%
CLAIMS PRO	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
PAY SAFE	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
PROD INVEST	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
STATE CERT	98.4848%	94.6040%	94.6040%	97.3372%	97.4280%	97.4285%	97.4271%	97.4282%	97.4282%
ESRD	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
ADMIN	66.9856%	67.7549%	67.0069%	67.3639%	67.3001%	67.3001%	67.3001%	67.3001%	67.3001%

GENERAL FUND OBLIGATIONS TO OUTLAYS

	FY 1984	FY 85 OLD	FY 85 NEW	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
RESEARCH	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
STATE CERT	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
ADMIN	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%

HI PERCENTAGE OF TOTAL OBLIGATIONS

	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
RESEARCH	32.7014%	32.7000%	32.6980%	32.6963%	32.7010%	32.6972%	32.6972%	32.6972%
PSRO	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
CLAIMS PRO	22.6999%	22.7000%	22.7000%	22.7000%	22.7000%	22.7000%	22.7000%	22.7000%
PAY SAFE	22.7000%	22.7000%	22.7000%	22.7000%	22.7000%	22.7000%	22.7000%	22.7000%
PROD INVEST	22.7000%	22.7000%	22.7000%	22.7000%	22.6993%	22.7000%	22.7000%	22.7000%
STATE CERT	67.5000%	67.5000%	67.5000%	67.5000%	67.5000%	67.5000%	67.5000%	67.5000%
ESRD	5.3000%	5.3000%	5.3000%	5.3000%	5.3000%	5.3000%	5.3000%	5.3000%
ADMIN	60.0000%	60.0000%	60.0000%	60.0000%	60.0000%	60.0000%	60.0000%	60.0000%

TRUST FUND OBLIGATIONS TO OUTLAYS

	FY 1984		FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
	HI	SMI							
RESEARCH	98.8230%	98.7968%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
PSRO	100.0000%	100.0000%	94.1176%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
CLAIMS PRO	95.0000%	95.0000%	97.2576%	97.3695%	97.4787%	97.5757%	97.6622%	97.7456%	97.7456%
PAY SAFE	95.0035%	94.9990%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
PROD INVEST	94.9951%	95.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
STATE CERT	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
ESRD	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
ADMIN	99.4322%	99.4322%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%

CURRENT SERVICES INFLATION FACTORS

	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
PSRO HR	100.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%
PSRO	-100.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%
RESEARCH	5.7402%	4.3000%	4.2000%	4.0000%	3.7000%	3.4000%	3.4000%
CLAIMS PRO	14.7795%	4.3000%	4.2000%	4.0000%	3.7000%	3.4000%	3.4000%
PAY SAFE	-0.1354%	4.3000%	4.2000%	4.0000%	3.7000%	3.4000%	3.4000%
PROD INVEST	21.0066%	4.3000%	4.2000%	4.0000%	3.7000%	3.4000%	3.4000%
STATE CERT	25.6540%	4.8000%	4.6000%	4.4000%	4.0000%	3.7000%	3.7000%
ESRD	0.0010%	4.8000%	4.6000%	4.4000%	4.0000%	3.7000%	3.7000%
ADMIN							
PAY	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%
NON-PAY	20.6535%	4.4000%	4.2000%	4.0000%	3.7000%	3.4000%	3.4000%
% PAY	71.0000%	71.0000%	71.0000%	71.0000%	71.0000%	71.0000%	71.0000%
% NON-PAY	29.0000%	29.0000%	29.0000%	29.0000%	29.0000%	29.0000%	29.0000%

FY 1987
GRANTS TO STATES FOR MEDICAID

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JUSTIFICATION

GRANTS TO STATES FOR MEDICAID
(SOCIAL SECURITY ACT, TITLE XIX, SECTION 1901)

AUTHORIZATION: Indefinite
(Dollars in Thousands)

Program Activity	FY 1986 Pending Request (Proposed Law)	FY 1986 Current Law Estimate	FY 1987 Request	Difference
Medical Assistance Payments (MAP)........	$ 22,494,659	$23,022,401	$24,559,596	$ 1,537,195
State and Local Administration (A&T)..	1,195,810	1,284,940	1,347,892	+62,952
Total Current Law Obligations...........	$ 23,690,469	$24,307,341	$25,907,488	$+1,600,147
Prior Year Carry-over............	$ ---	$ -171,849	$ ---	$ +171,849
Total Current Law Appropriation.........	$ 23,690,469	$24,135,492	$25,907,488	$+1,771,996

RATIONALE FOR THE BUDGET REQUEST

The Medicaid budget requirements reflected herein are based upon the quarterly estimates (Form HCFA-25) submitted by the States in May 1985, as adjusted by HCFA. Included are updated State estimates for FYs 1985 and 1986, as well as the States' initial projections for FY 1987. This budget has been prepared consistent with current law and does not include the impact of proposed legislation.

The States are projecting FY 1987 Medicaid total costs of $48.7 billion, which would require a Federal share of $27.1 billion. The adjusted Federal share reflected in this request is $25.9 billion, which represents an increase of $1.6 billion over the current estimate of $24.3 billion for FY 1986 grant awards. The various program and financial adjustments made to the raw States' estimates in formulating anticipated funding requirements for FY 1987 are presented in the following table.

FY 1985-87 FUNDING REQUIREMENTS
FEDERAL SHARE
(Dollars in Thousands)

	FY 1985	FY 1986	FY 1987
States' Estimates (MAP + A&T)	$22,861,051	$25,137,099	$27,019,734
State Certification	39,610	44,811	48,601
Fraud Control Units	28,494	42,931	44,153
TOTAL ESTIMATES	$22,929,155	$25,224,841	$27,112,488
ADJUSTMENTS			
Financial Adjustments	-550,000	-700,000	-850,000
MQC Disallowances	-53,000	-17,500	-50,000
TPL Savings	---	-200,000	-300,000
Section 1903(t) Incentive Rebates			
FY 1984	+380,623	---	---
Prior Year Adjustments	-16,072	---	---
Prior Year Claims	+122,047	---	---
Medicare Regulatory Impact	---	---	-5,000
TOTAL CURRENT LAW OBLIGATIONS (% Change)	$22,812,753	$24,307,341 (6.6%)	$25,907,488 (6.6%)
Unobligated Balance Start of Year	-1,139,111	-171,849	---
Surplus (+)/Deficit (-) End of Year	+171,849	---	---
TOTAL CURRENT LAW APPROPRIATION	$21,845,491	$24,135,492	$25,907,488

States' Estimates

The States' May estimates for FYs 1985 and 1986 have declined by nearly $250 million and $100 million, respectively, since the February budget submission. For both those years, decreases in estimated medical assistance payments are partly offset by slight increases for State and local administration. Although expenditure projections continue to rise, the States' initial estimates for FY 1987 show a growth rate of 7.5 percent, which is considerably lower than the 10.0 percent growth rate currently forecast for FY 1986 over FY 1985. The reasons for the anticipated growth between FY 1986-87, as well as for the FY 1986 changes between the February and May submissions, are explained in the individual State narratives which appear later in this justification.

State Certification

As authorized in Sections 1903(a)(2) and (7) of the Social Security Act, HCFA provides oversight and Federal reimbursement to States for conducting survey and certification activities for Medicaid long-term care (LTC) facilities. In FY 1987, there will be an estimated 2,320 Skilled Nursing Facilities; 3,750 Intermediate Care Facilities for the Mentally Retarded; and 11,725 Intermediate Care Facilities (All Other) certified for participation in the Medicaid program. Quarterly grants to States provide Federal reimbursement for 75 percent of costs for surveyor salaries, fringe benefits, travel, and training, and 50 percent of all other survey related expenditures. For FY 1987, Federal funding required to support Medicaid survey activities is $48,601,000. This level of Federal support provides for annual inspections of all LTC facilities currently participating in the program as well as initial surveys of newly eligible facilities and, where appropriate, follow-up inspections.

Fraud Control Units

The Medicaid program provides for 75% Federal financial participation for the operation of State Medicaid Fraud Control Units (SMFCUs). These organizations are involved in the identification, investigation, and prosecution of Medicaid fraud. In addition, SMFCUs review, investigate, and prosecute cases of patient abuse or neglect and make recommendations to the State Medicaid agencies for improvements in their program. The Office of the Inspector General, which is responsible for SMFCU oversight, estimates a funding requirement of $44,153,000 for FY 1987. This amount provides for maintenance of the FY 1986 level of effort.

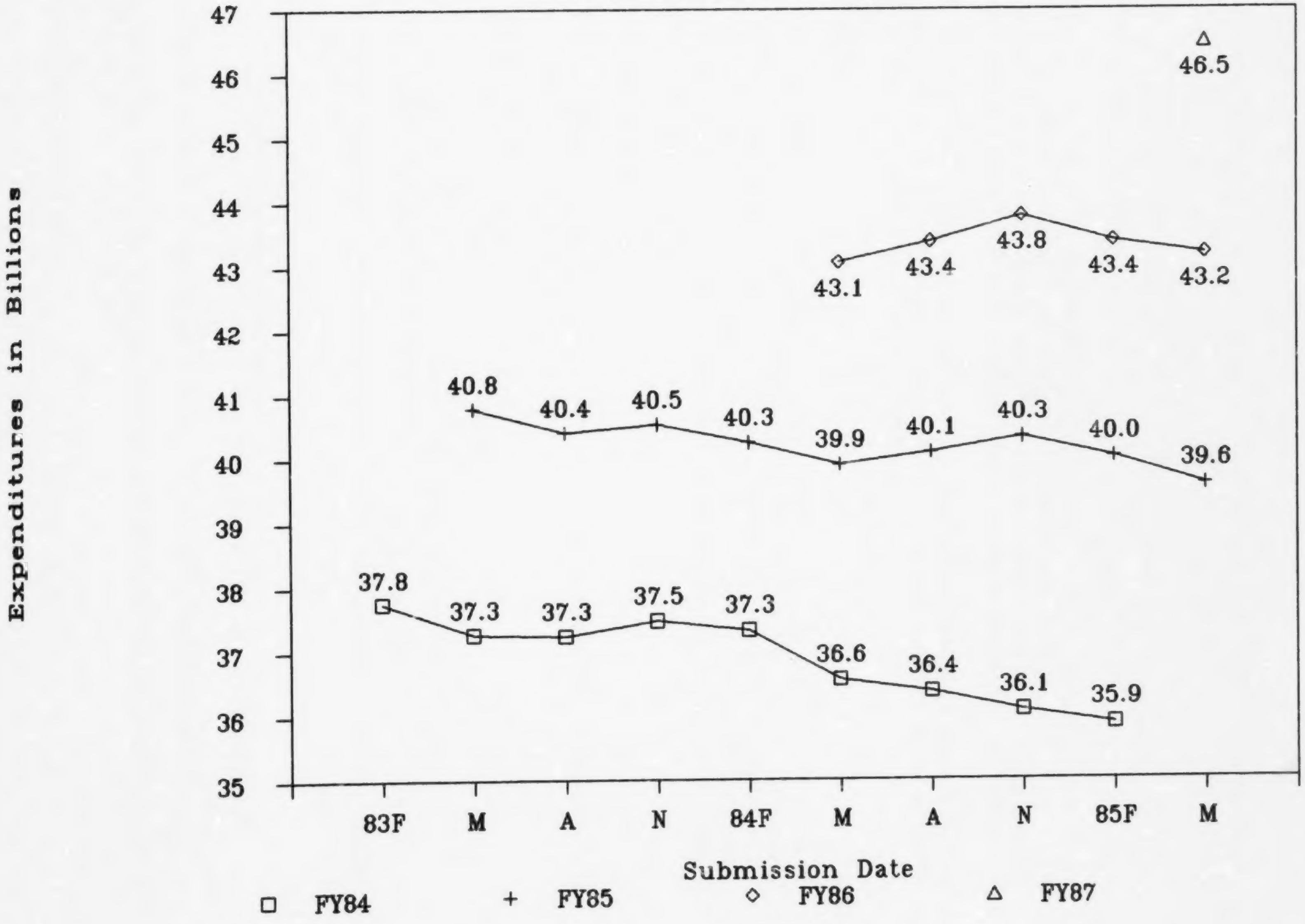
Financial Adjustments

As anticipated, the States have lowered their projections for fiscal years 1985 and 1986. (See the following chart which illustrates the trend in the States' variances for FY 1984, 1985 and 1986 MAP estimates.) Nonetheless, independent budget projections developed by HCFA indicate that the States' estimates are still overstated by $550 million for FY 1985 and $700 million for FY 1986, or approximately 2 to 3 percent. On the basis of that analysis, FY 1987 is also projected to be overstated by approximately 3%, or $850 million. Consequently, the States' estimates have been reduced by those amounts to arrive at final funding projections.

Of the $550 million reduction in FY 1985, $170 million is related to finalization of prior fiscal year grant awards and $380 million is attributable to overstatement of FY 1985 funding requirements.

State Estimates Over Time

Total Computable Expenditures



MQC Disallowances

Savings associated with MQC disallowances under Michel and TEFRA regulations are estimated at $53 million for FY 1985; $25 million for FY 1986; and $50 million for FY 1987. The amount shown for FY 1985 represents final disallowances for Michel I ($12.6 million) and those anticipated for Michel II ($40.6 million). States' waiver requests for Michel II sanctions are currently under review, and HCFA expects to make its recommendations to the Secretary shortly.

A total of $25 million in disallowances is estimated to be taken in FY 1986 under TEFRA I (the period covering April-September 1983). However, of this amount, $7.5 million was prospectively withheld and is already reflected in the base. Consequently, only the balance of $17.5 million is shown as an adjustment to the States' estimates.

Error rates for the TEFRA period covering FY 1984 have not yet been projected. The total disallowance of $50 million shown to be taken in FY 1987 represents a preliminary estimate based on Michel II and TEFRA I experience.

TPL Savings

The Medicaid program is the "payor of last resort." As the cost of the Medicaid program has risen dramatically in recent years, interest in the use of third party resources to minimize Medicaid expenditures has grown considerably. Beginning in FY 1985, as part of its Medicaid oversight strategy, HCFA is developing several approaches designed to induce the States to establish more aggressive third party liability management systems.

These approaches are:

- Provide guidance to States and act as a clearinghouse for successful TPL practices
- Strengthen TPL regulations to require:
  - data match with additional TPL sources
  - TPL identification for Medicaid eligibles
  - cost-avoidance emphasis (rather than "pay and chase" methods)
  - automated use of TPL information
- Establish regulatory authority to allow HCFA to take projected disallowances for TPL errors.
- Collect data to target Federal oversight/audit:
  - inventory State TPL programs
  - refine cost data reported on quarterly Expenditure Reports (HCFA-64)
- Recover misspent funds through a series of TPL audits in selected States

Savings resulting from implementation of these efforts are estimated at $200 million in FY 1986 and $300 million in FY 1987.

Medicare Regulatory Impact

The $5 million negative adjustment to the States' estimates for FY 1987 represents the indirect impact on Medicaid of regulations reflected in the Medicare budget.

NATIONAL TRENDS

Medical Assistance Payments

Analysis of the budget estimates submitted by the States in May 1985 indicates that anticipated medical care price inflation accounts for 72 percent of the increase in total medical assistance payments (Federal and State shares) projected for FY 1987. Another 22 percent is attributable to the combined impact of expected growth in the recipient population and rising utilization rates. The remaining 6 percent is not specifically identified by the States in their submissions to HCFA.

While expenditures for all categories of service are expected to increase, 57 percent of the total rise foreseen in medical assistance payments is associated with services provided in Inpatient Hospital, Skilled Nursing Facility, and Intermediate Care Facility settings. The following table shows a distribution of program growth by the major service categories, as well as the percentage increase over FY 1986 for each category.

	Pct. of Total Growth in FY 1987	Pct. Increase over FY 1986 Expenditures
Inpatient Hospital	22.3%	7.1%
ICF/All Other	12.8	6.3
Skilled Nursing Facility	12.0	6.8
Personal Care	8.4	28.5
ICF/MR - Public	6.9	5.5
Prescribed Drugs	6.4	8.3
Health Insurance	5.5	11.3
Physician	5.1	6.5
Outpatient Hospital	4.4	7.2
ICF/MR - Private	3.0	9.0
Mental Health Facility	2.9	6.9
Other	10.3	8.9
Total	100.0%	7.6%

Although inpatient hospital and nursing home costs account for 57 percent of the FY 1987 cost increase, the annual rate of growth from FY 1985-7 for these services appears to be gradually slowing. As a result, their relative share of total Medicaid expenditures is decreasing commensurately, as may be seen on the following table which shows MAP estimates by type of service. For example, inpatient hospital services represent 24.7 percent of total Medicaid costs (before cashflow adjustments) for FY 1985; by FY 1987, however, the relative share of those costs is expected to drop to 23.8 percent, a decrease of nearly one percentage point.

Additionally, if State projections for a showdown in the growth rate for nursing home (SNF and ICF) services prove to be accurate, this will be a significant reversal of the trend of the last 10 years, wherein the rate of growth for these services represented the fastest rising component of Medicaid costs.

Projected rates of increase for other categories of service range from a low of 2.9 percent for Mental Health Facility services to a high of 28.5 percent for Personal Care services. Growth in the Personal Care category is skewed by the State of New York, however, which accounts for over 80 percent of national expenditures for such services. Excluding New York, the adjusted rate of growth for Personal Care is 4.5 percent.

Similarly, health insurance payments are somewhat distorted by large increases projected for Ohio. Excluding Ohio, the adjusted rate of growth for insurance premium costs is 7.2 percent, which is more in line with the overall Medicaid growth factor of 7.6 percent.

Just as the majority of the overall increase in medical assistance payments can be traced to a few institutional service types, likewise, it can be associated with a small group of States. Three States — California, Florida, and New York — alone comprise 42.3 percent of the national total. Michigan, New Jersey, Ohio, Tennessee, and Texas are each projecting increases in total expenditures in excess of $100 million; combined, these five States account for another 21.7 percent of the FY 1987 increase.

MEDICAL ASSISTANCE PAYMENT ESTIMATES
BY TYPE OF SERVICE
FISCAL YEARS 1985-1987
(Dollars in Millions)

	FISCAL YEAR 1985		FISCAL YEAR 1986		FISCAL YEAR 1987	
	Amount	Percent	Amount	Percent	Amount	Percent
Inpatient Hosp.	$ 5,365	24.67	$ 5,716	23.95	$ 6,125	23.85
ICF/All Other	3,628	16.68	3,897	16.34	4,146	16.14
Skilled Nursing Facility	2,853	13.12	3,104	13.01	3,316	12.91
ICF/MR - Public	2,164	9.95	2,276	9.54	2,404	9.36
Prescribed Drugs	1,304	6.00	1,450	6.08	1,570	6.11
Physician	1,359	6.25	1,462	6.13	1,559	6.07
Outpatient Hospital	945	4.35	1,045	4.38	1,126	4.38
Health Insurance Payments	694	3.19	895	3.75	998	3.88
All Other	608	2.80	748	3.14	820	3.19
Mental Health Facilities	672	3.09	743	3.11	794	3.09
ICF/MR - Private	515	2.37	602	2.52	657	2.56
Personal Care	403	1.85	494	2.07	633	2.46
Clinic	316	1.45	340	1.43	367	1.43
Dental	270	1.24	295	1.24	313	1.22
HCBS Waiver	171	0.79	255	1.07	268	1.04
Home Health	170	0.78	191	0.80	217	0.84
Other Practitioner	129	0.59	140	0.59	152	0.59
Lab & Radiological	119	0.55	133	0.56	149	0.58
EPSDT Screening	57	0.26	65	0.27	71	0.28
Rural Health Clinic	5	0.02	5	0.02	6	0.02
Subtotal	$21,747	100.00	$23,856	100.00	$ 25,691	100.00
State Estimated Cash Flow	-54		33		23	
Total State Estimates	$21,693		$23,889		$ 25,714	

A & T Expenditures

The following table illustrates estimated Medicaid Administration costs by matching rate. The trend over FY 1985-87 shows a steady decline in the portion of costs matched at a 90% incentive rate, suggesting a decrease in MMIS developmental activities for the short term.

Administration Costs FY 1985-7
(Dollars in Thousands)

	FY 1985	FY 1986	FY 1987
90% Match			
Medicaid Management Information Systems	$ 23,113	$ 16,547	$ 13,111
Other	7,237	7,465	7,669
75% Match			
Medicaid Management Information Systems	321,309	345,235	361,140
Skilled Professional Medical Personnel	178,287	191,605	201,629
50% Match			
Non-MMIS Mechanized Claims Processing	16,730	19,194	21,678
Other	585,077	627,005	654,241
Subtotal	$ 1,131,753	$ 1,207,051	$ 1,259,468
State Estimated Cash Flow	35,911	40,147	45,670
Total State Estimates	$ 1,167,664	$ 1,247,198	$ 1,305,138

Recipient Data

The following table reflects the estimated annual unduplicated number of recipients (by basis of eligibility) receiving Federal medical assistance under the Medicaid program. The data are based upon HCFA-25 submissions from the States and the HCFA-2082, Statistical Report on Medical Care.

	Number of Recipients (In Thousands)		
	FY 1985	FY 1986	FY 1987
Aged 65 and Over	3,013	3,142	3,183
Blind and Disabled	2,995	3,075	3,128
AFDC Adults	5,297	5,434	5,544
AFDC Children	9,195	9,404	9,576
Other Children	1,354	1,496	1,489
TOTAL	21,854	22,461	22,920

SUMMARY COMPARISON FY 1985-7

(Dollars in Thousands)

	Medical Assistance Payments	Administration	Total
Fiscal Year 1985	$21,693,387	$1,167,664	$22,861,051
Fiscal Year 1986	23,889,901	1,247,198	25,137,099
Fiscal Year 1987	25,714,596	1,305,138	27,019,734
Fiscal Year Difference			
1985 to 1986			
Amount:	$ 2,196,514	$ 79,534	$ 2,276,048
Percent:	10.13	6.81	9.96
1986 to 1987			
Amount:	$ 1,824,695	$ 57,940	$ 1,882,635
Percent:	7.64	4.65	7.49

SUMMARY OF CHANGES IN STATES' FY 1986 ESTIMATES

FEBRUARY 1985 TO MAY 1985 SUBMISSION
MAP AND A&T
(Dollars in Thousands)

	FEBRUARY SUBMISSION	MAY SUBMISSION	DOLLAR GROWTH	PERCENT GROWTH
INCREASES:				
California	$ 2,360,066	$ 2,517,416	$ 157,350	6.67
Indiana	483,905	531,116	47,211	9.76
Ohio	1,247,738	1,284,360	36,622	2.94
South Carolina	308,992	334,862	25,870	8.37
All Other (23 States)	5,318,418	5,417,599	99,181	1.86
SUBTOTAL	$ 9,719,119	$ 10,085,353	$ 366,234	3.77
DECREASES:				
New York	$ 4,723,817	$ 4,614,271	$ -109,546	-2.32
Tennessee	587,485	533,491	-53,994	-9.19
Michigan	1,223,482	1,178,079	-45,403	-3.71
Texas	1,055,194	1,011,809	-43,385	-4.11
Mississippi	304,124	262,038	-42,086	-13.84
Florida	700,403	658,957	-41,446	-5.92
North Carolina	523,927	489,071	-34,856	-6.65
Virginia	359,654	334,160	-25,494	-7.09
All Other (14 States)	5,265,121	5,196,112	-69,009	-1.31
SUBTOTAL	$ 14,743,207	$ 14,277,988	$ -465,219	-3.16
No Changes (8 States)	$ 773,758	$ 773,758	$ 0	0.00
TOTAL	$ 25,236,084	25,137,099	$ -98,985	-0.39

EXPLANATION OF CHANGES IN STATE ESTIMATES
FEBRUARY TO MAY SUBMISSION
FISCAL YEAR 1986

CALIFORNIA

Total: $+157.3 million, + 6.7%
MAP: $+133.3 million, + 6.0%
ADM: $+ 24.0 million, +15.9%

California has revised its FY 1986 medical assistance payment (MAP) forecast since February to reflect updated FY 1985 expenditure trends, and has increased both its recipient and price inflation assumptions.

Slightly over half of the growth is attributable to increase in reimbursement rate assumptions for institutional services. An increase in long term care rates became effective in March 1985. The following reflects the change in institutional services estimates since February:

- Skilled Nursing Facilities, $42.3 million increase;
- Inpatient Hospitals, $18.5 million increase; and
- Intermediate Care Facilities for the Mentally Retarded, $8.9 million increase.

Outpatient Hospital estimates were reduced $12.4 million to reflect a respective 5.3 and 7.0 percent decline in price and utilization assumptions.

California also significantly increased projections due to anticipated lawsuits and cash flow adjustments by $41.3 million and $25.9 million, respectively. Finally, revised recipient and utilization trends in all other categories of service added $8.8 million to MAP estimates.

The $24.0 million increase in administration results from a $12.6 million rise in fiscal agent costs combined with an $11.4 million increase in salaries for State employees.

INDIANA

Total: $+47.2 million, + 9.8%
MAP: $+47.1 million, +10.1%
ADM: $+ 0.1 million, + 0.8%

Since the February budget submission, Indiana has revised its FY 1986 medical assistance payment projection to reflect new submissions arising from updated trend data through the first two quarters of FY 1985. The State has substantially increased the utilization levels it expects in most service categories in FY 1986 due to the rapid rise in recipients in the last 6 months (because of growing unemployment and the implementation of the Deficit Reduction of 1984) as well as growth in the rate in which recipients are using services. Furthermore, Indiana now anticipates processing 53 claims payment runs in FY 1986 rather than the usual 52. These factors are responsible

EXPLANATION OF CHANGES IN STATE ESTIMATES
FEBRUARY TO MAY SUBMISSION
FISCAL YEAR 1986

INDIANA (Cont.)

for increases of $21.6 million for Intermediate Care Facility (ICF)/All Other, $8.8 million for Inpatient Hospital, $6.5 million for ICF/Mentally Retarded, $5.9 million for Skilled Nursing Facility, and $2.6 million for Physician services. The remainder of the rise in the State's projected medical assistance payments since the previous submission is accounted for by the net impact of minor increases and decreases in the estimates for all other categories of service.

OHIO

Total: $+36.6 million, + 2.9%
MAP: $+32.3 million, + 2.7%
ADM: $+ 4.3 million, +11.8%

Even though Ohio has lowered its medical assistance payment estimate for FY 1985 since the February submission, it has slightly raised projected medical payments for FY 1986. While the FY 1985 estimate includes 2 quarters of actual and 2 quarters of projected expenditures, the FY 1986 estimate is derived by means of a regression analysis using the last 14 quarters of available expenditure data.

SOUTH CAROLINA

Total: $+25.9 million, +8.4%
MAP: $+25.9 million, +8.8%
ADM: -

South Carolina's MAP estimate for FY 1986 has been increased to reflect the addition of medical payments for an AFDC eligibility expansion - Unemployed Parent Program. Approximately 18,000 recipients are expected to be served in FY 1986 under this new eligibility group. Increases since February in the following service categories reflect the impact of the eligibility expansion:

- Inpatient Hospitals, $13.1 million, 18.2 percent;
- Prescribed Drugs, $5.2 million, 19.2 percent;
- Physicians, $4.0 million, 19.3 percent;
- Outpatient Hospitals, $1.8 million, 19.2 percent;
- Clinics, $0.7 million, 44.1 percent;
- Dental services, $0.7 million, 19.3 percent; and
- All other noninstitutional services, $0.4 million, 2.0 percent.

EXPLANATION OF CHANGES IN STATE ESTIMATES
FEBRUARY TO MAY SUBMISSION
FISCAL YEAR 1986

NEW YORK	Total:	$-109.5 million, -2.3%
	MAP:	$-132.3 million, -2.9%
	ADM:	$ +22.8 million, +10.3%

New York reduced their MAP estimates for FY 1986 by $132.3 million to reflect reductions in their current expenditure base and to adjust assumptions for the following categories of service:

- o Inpatient Hospitals, $35.6 million decrease - recipient and price projections were lowered to reflect recent claiming trends;
- o Skilled Nursing Facilities, $35.3 million decrease - half of the decline results from lower projections for the impact of rate increases and levels of appeals - the remaining decline reflects base adjustments for recent expenditure trends;
- o Private ICFs/MR, $30.0 million decrease - primarily due to base adjustments for claiming delays;
- o Other Care services, $17.1 million decrease - resulting from trending forward negative one-time claiming adjustments experienced in recent quarters;
- o Mental Health Facilities, $9.6 million decrease - base adjustments were lowered for recent expenditure trends. Additionally, bed increase estimates were reduced by the Office of Mental Health to bring projections down to historical claiming and program growth trends; and
- o All Other Categories, a net $4.7 million decrease.

The increase in administration estimates results primarily from the rise in prior period claiming for the Department of Health, Office of Mental Health, and the Office of Mental Retardation and Developmental Disabilities.

TENNESSEE	Total:	$-54.0 million, -9.2%
	MAP:	$-49.9 million, -8.8%
	ADM:	$ -4.1 million, -22.0%

Tennessee's February estimates for FY 1986 expenditures were based on FY 1985 projections trended forward for economic assumptions. Because the FY 1985 projections did not reflect current claiming experience, the FY 1986 estimate submitted in February was also inflated. In the May submission, Tennessee significantly reduced their FY 1985 estimate in an attempt to portray actual claiming experience. The current FY 1986 estimate was reduced accordingly.

TENNESSEE (Cont.)

Administration estimates were lowered to reflect a revised cost allocation plan which transferred some of the in-house MMIS operational costs to lesser Federal financial participation.

MICHIGAN		
	Total:	$-45.4 million, -3.7%
	MAP:	$-45.2 million, -3.8%
	ADM:	$- 0.2 million, -0.5%

Since the February budget submission, Michigan has revised its medical assistance payment estimate for FY 1986 to reflect two quarters of actual expenditures in FY 1985. The level of medical assistance payments in FY 1985 has been lower than previously anticipated due primarily to an unforeseen drop in the utilization rates of most service types. This factor is largely responsible for decreases of $8.0 million for Intermediate Care Facility/All Other, $6.4 million for Inpatient Hospital, $5.1 million for Physician, $4.4 million for Dental, and $2.8 million for Skilled Nursing Facility services. Another $8.3 million of the decline is attributable to decreases in most remaining categories offset to a degree by a slight increase in the miscellaneous services reported under Other. The final $10.2 million in the drop from the previous submission results from a lowering of the anticipated family planning expenditures eligible for 90 percent Federal reimbursement.

TEXAS		
	Total:	$-43.4 million, -4.1%
	MAP:	$-47.0 million, -4.8%
	ADM:	$+ 3.6 million, +5.0%

The reduction in Texas' medical assistance payment estimate since the February budget submission is comprised of two components: a $34.8 million drop in the State's program estimates for benefit payments and $12.2 million in cash flow adjustments which will decrease the State's funding requirements. The most substantially changed program estimates are for Inpatient Hospital and Physician services which were lowered $25.7 million and $12.1 million, respectively, primarily as a result of revised price assumptions. A net increase of $3.0 million arising from lesser increases and decreases in all other categories of service partially offset these large reductions. Texas now projects that premium credit refunds of $10.9 million and various collections totalling $1.3 million will reduce its funding needs by corresponding amounts, whereas no cash flow adjustments were forecast in its previous budget submission.

The increase in the State's projected administration expenditures since February is largely the result of an updated estimate of the costs associated with the State's expanded coverage of recipients (pregnant women and children, as well as a medically needy program.)

EXPLANATION OF CHANGES IN STATE ESTIMATES
FEBRUARY TO MAY SUBMISSION
FISCAL YEAR 1986

MISSISSIPPI

Total: $-42.1 million, -13.8%
MAP: $-43.9 million, -14.7%
ADM: $+ 1.8 million, +32.9%

Service limitations imposed in FY 1985 are now expected to continue into FY 1986 and explain the decline in FY 1986 MAP estimates from February to May. Limitations imposed in the following service categores represent $42.2 million, 96.1 percent, of the total decrease in MAP estimates:

- o Inpatient Hospitals, $20.6 million decrease;
- o Intermediate Care Facilities, $8.3 million decrease;
- o Prescribed Drugs, $7.4 million decrease;
- o Physicians, $5.9 million decrease.

Administration estimates have increased as a result of an anticipated rise in fiscal agent costs of $1.8 million.

FLORIDA

Total: $-41.4 million, - 5.9%
MAP: $-33.9 million, - 5.1%
ADM: $ -7.5 million, -17.9%

Florida's FY 1986 estimate has been reduced since February to reflect the results of a recent comprehensive study conducted to determine the effect of implementing the AFDC-like eligibility groups mandated by the State's Health Care Access Act of 1984. Recipient and utilization assumptions were collectively reduced by $44.7 million since February as a result of this study. A $10.8 million increase in price assumptions is explained by the addition of new pre-paid health plans, particulary for SSI recipients.

The recipient caseload expansion over FY 1985 was originally projected at 148,000 recipients. Current estimates have reduced the recipient expansion to approximately 75,800 recipients. The following service category reductions comprise $44.1 million, or 98.7 percent, of the total decline due to revised recipient estimates:

- o Inpatient Hospitals, $32.0 million decrease;
- o Outpatient Hospitals, $ 5.6 million decrease;
- o Physicians, $3.8 million decrease; and
- o Prescribed Drugs, $2.7 million decrease.

Administrative estimates were also significantly reduced due to results from the expansion study.

EXPLANATION OF CHANGES IN STATE ESTIMATES
FEBRUARY TO MAY SUBMISSION
FISCAL YEAR 1986

NORTH CAROLINA

Total: $-34.9 million, -6.7%
MAP: $-35.1 million, -6.9%
ADM: $ +0.2 million, +1.0%

Medical assistance payment (MAP) estimates for FY 1986 have been reduced to reflect recent expenditure payment trends. Since February, the FY 1985 MAP estimate was reduced $15.7 million as a result of estimates exceeding actual expenditures. This was fueled somewhat by an increased effort by the fiscal agent in the editing and auditing of claims for denial. The decline in the FY 1985 estimate has been trended out through FYs 1986 and 1987. Reduced estimates in the following categories of service comprise $31.9 million, 90.9 percent of the decline in FY 1986 MAP estimates:

- Inpatient Hospitals, $13.9 million decrease;
- Skilled Nursing Facilities, $7.0 million decrease;
- Intermediate Care Facilities/All Other, $5.7 million decrease; and
- Physicians, $5.3 million decrease.

Administration (ADM) estimated growth consists of the following:

- Medicaid Management Information Systems (MMIS) and Other Mechanized Systems, $0.1 million decrease;
- Design and Developmental MMIS, $0.6 million increase; and
- All Other ADM, $0.3 million decrease.

VIRGINIA

Total: $-25.5 million, -7.1%
MAP: $-25.2 million, -7.3%
ADM: $- 0.3 million, -2.0%

Virginia has revised its February estimates for medical assistance payments to reflect lower than anticipated expenditure trends during the first two quarters of FY 1985. Since the FY 1985 estimates serve as the basis for the FY 1986 projections, the State has made a corresponding reduction in its FY 1986 forecast. Approximately $17.2 million of the total change in FY 1986 medical assistance payment estimates is accounted for by decreased projections of $3.7 million for Inpatient Hospitals, $5.5 million for Intermediate Care Facility (ICF)/Mentally Retarded and $8.0 million for ICF/All Other. The remainder of the decrease, $8.0 million, is accounted for by minor decreases anticipated in all other categories of service.

SUMMARY OF CHANGES IN STATE ESTIMATES
GROWTH BETWEEN FY 1986 - 1987
(Dollars in Thousands)

	FY 1986	FY 1987	DOLLAR GROWTH	PERCENT GROWTH
New York	$ 4,614,271	$ 5,075,313	$ 461,042	9.99
Florida	658,957	801,262	142,305	21.60
California	2,517,416	2,643,281	125,865	5.00
Ohio	1,284,360	1,393,079	108,719	8.46
Texas	1,011,809	1,103,877	92,068	9.10
Tennessee	533,491	615,296	81,805	15.33
Michigan	1,178,079	1,254,286	76,207	6.47
SUBTOTALS	$ 11,798,383	$ 12,886,394	$ 1,088,011	9.22
All Other (49 States)	13,338,716	14,133,340	794,624	5.96
TOTALS	$ 25,137,099	$ 27,019,734	$ 1,882,635	7.49

EXPLANATION OF CHANGES IN STATE ESTIMATES
GROWTH BETWEEN FY 1986 - 1987

NEW YORK		
	Total:	$+461.0 million, +10.0%
	MAP:	$+449.5 million, +10.3%
	ADM:	$ +11.5 million, +4.7%

The most significant factor influencing New York's medical assistance payment (MAP) growth from FY 86 to FY 87 is rate inflation which comprises $290.4 million, 64.5 percent of the total MAP increase. Growth due to recipient/utilization factors is estimated at $174.4 million, while one-time claiming and cash flow adjustments are expected to decline $15.3 million.

Rate increases in Inpatient Hospitals, Skilled Nursing Facilities (SNFs), Public Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), and Personal Care services represent $200.9 million, 69.2 percent, of the total price related growth as follows:

1. The New York Prospective Hospital Reimbursement Methodology (NYPHRM), implemented in calendar year (CY) 1983 as an approved HCFA demonstration project, expires at the end of CY 1985. The current submission's Inpatient Hospital price projections for FYs 1985 through 1987 were calculated under the NYPHRM guidelines and reflect an $82.6 million, 8.2 percent increase, over FY 1986. The State is currently assessing several options and their limitations as a payment system for Inpatient Hospital services. Proposed legislation for any one of these options, however, will not be introduced until July 1985. These options include:

   - Continuing the NYPHRM with some refinements, e.g., more stringent length of stay standards;

   - Continuing NYPHRM for all payors other than Medicare, i.e., Medicaid, Blue Cross, commercial payors, workman's compensation, no-fault and self-pay patients - the Medicare reimbursement methodology would be the prospective payment system (PPS) developed by HCFA; and

   - Implementing Medicare's PPS for Medicare beneficiaries - for all other payors and patients, the State would use a reimbursement methodology based on diagnostic-related-groups and New York State cost and utilization data.

2. Effective January 1, 1986, New York is implementing a case mix reimbursement methodology called Resource Utilization Groups for SNFs. This new methodology allows reimbursement of facility needs based on characteristics of the clients in the facility and is expected to match resources with patients' needs. Ultimately, this new reimbursement system will improve the management, planning, control, and organization of SNFs. The estimated rate of increase for FY 1987 over FY 1986 is 6.7 percent, $55.1 million.

EXPLANATION OF CHANGES IN STATE ESTIMATES
GROWTH BETWEEN FY 1986 - 1987

NEW YORK (Cont.)

3. Projected per-diem rate increases for FY 1986 to 1987 for ICFs/MR and Personal Care services are as follows:

   o 8 percent, $31.9 million increase, for ICFs/MR; and

   o 6 percent, $31.3 million increase, for Personal Care services.

The expansion in New York's aged population is the driving force behind the State's projected recipient/utilization related growth. Aged recipient caseloads are expected to increase by approximately 4 percent over FY 1986 while zero growth is anticipated in all other recipient caseloads. Expansions in the aged population and the number of certified Home Health Agencies coupled with the limited supply of long term care beds and increased utilization of home care alternatives, explain significant projected increases in Personal Care/Home Health services costs. The fiscal year 1986 - 1987 increase in these home care services due to recipient/utilization factors is estimated at $114.8 million and represents 65.8 percent of the total recipient/utilization related growth.

The majority of New York's administrative (ADM) expenditures are for support of local district staffs throughout the State. Inflationary pressures that impact upon salary and other non-personal services costs are expected to range from 5 to 6 percent for New York City and from 4 to 5 percent for the rest of the State.

FLORIDA
Total: $+142.3 million, +21.6%
MAP: $+129.1 million, +20.7%
ADM: $+ 13.2 million, +38.2%

On the basis of its expenditure projections, Florida will be one of the "Big Ten" Medicaid States, largely due to its implementation of a medically needy program beginning July 1986. This new coverage is expected to increase FY 1987 caseloads by more than 200,000 recipients, or 35 percent over FY 1986. Because medically needy recipients are expected to be utlizers of less costly services, however, the overall rate of increase for FY 1987 is projected at 21 percent.

The following chart displays the growth in service category estimates by assumption factors:

FY 1986 - 1987 MAP Service Growth
(Dollars in Millions)

	Recipient/ Utilization	Price	Total Growth Dollar	Total Growth Percent
Inpatient Hospital	$34.9	$15.4	$ 50.3	29.9
ICF/All Other	14.8	12.9	27.7	17.0
Prescribed Drugs	8.9	4.1	13.0	23.9
Outpatient Hospitals	10.1	2.3	12.4	38.4
Physicians	9.6	0.5	10.1	36.0
Other Long Term Care	0.8	7.6	8.4	7.3
All Other Services	5.8	1.4	7.2	11.3
Total	$84.9	$44.2	$129.1	20.7

EXPLANATION OF CHANGES IN STATE ESTIMATES
GROWTH BETWEEN FY 1986 - 1987

FLORIDA (Cont.)

Administration (ADM) expenditures are expected to increase by $11.8 million due to implementation of the medically needy program and from salary increases. Rising fiscal agent contract costs, $1.4 million, explain the remaining increase in ADM expenditures over FY 1986.

CALIFORNIA	Total:	$+125.9 million, +5.0%
	MAP:	$+117.1 million, +5.0%
	ADM:	$+ 8.8 million, +5.0%

Due to the State's budget cycle, no budget estimate for FY 1987 is available. Therefore, California is projecting an across the board increase of 5.0 percent ($125.9 million) overall growth rate between fiscal year 1986 and fiscal year 1987 for medical asistance payments and administration costs.

OHIO	Total:	$+108.7 million, +8.5%
	MAP:	$+108.3 million, +8.7%
	ADM	$+ 0.4 million, +1.1%

Rising price factors are the driving force behind the majority of the program growth anticipated by Ohio in FY 1986, along with slight rises in utilization rates for most service categories with the exception of Inpatient Hospital, where utilization rates are expected to drop somewhat. Price inflation and increased utilization are expected to raise expenditures for Skilled Nursing Facility, Intermediate Care Facility and ICF/All Other, and (ICF)/Mentally Retarded services by $18.0 million, $12.0 million, and $10.4 million, respectively. Price and utilization related increases will also be the primary cause of $10.4 million growth in Outpatient Hospital, $8.4 million for Prescribed Drugs, and $5.2 million for Physician services. Rising enrollment in Health Maintenance Organizations will be largely responsible for another $41.9 million in Health Insurance Payments. The balance of the projected rise in medical assistance payments is accounted for by the net impact of increases and decreases in all remaining categories of service.

EXPLANATION OF CHANGES IN STATE ESTIMATES
GROWTH BETWEEN FY 1986 - 1987

TEXAS		
	Total:	$+92.1 million, + 9.1%
	MAP:	$+93.5 million, + 10.0%
	ADM:	$- 1.4 million, - 1.9%

Approximately 40 percent of Texas' medical assistance payments are made through a premium arrangement with a health insurance agent. Services covered under this arrangement include Inpatient and Outpatient Hospital, Physician, Laboratory and Radiology, Optometric, Audiological, Ambulance, and Rural Health. Premium payments which are negotiated annually and paid monthly for each eligible recipient, are expected to rise by $46.4 million in FY 1986. This anticipated premium increase is distributed as follows: $25.6 million for Inpatient Hospital, $12.5 million for Physician, $3.5 million for Outpatient Hospital, $3.1 million for Laboratory and Radiology, and $1.7 million for the other services covered by the health insurance arrangement.

In the service categories not covered under the premium payment plan, Texas is projecting program growth totaling $25.8 million. The State expects price inflation to account for most of the growth with utilization rates remaining relatively level, with the exception of Mental Health Facility. An increase in patient days will be the major cause of $14.4 million growth in Mental Health Facility services. Higher reimbursement rates will be largely responsible for increases of $6.8 million for Intermediate Care Facility (ICF)/Mentally Retarded, and $2.1 million for ICF/All Other, as well as minor increases in most other service types totaling $2.5 million.

Texas has included an additional $10.4 million in estimated medical assistance payment growth to account for expansion in its new medically needy program, as well as the categorically needy coverage of pregnant women and children.

The magnitude of the rise in Texas' projected medical assistance payments between FYs 1986 and 1987 is distorted by a $10.8 million dollar variance in the cash flow adjustments (primarily premium credit refunds) which are expected to reduce the funding requirements in each of the 2 years. If the impact of these cash flow adjustments is removed from both years' estimates, the State is projecting medical assistance payment growth of $82.6 million, 8.7 percent, in FY 1987.

TENNESSEE		
	Total:	$+81.8 million, +15.3%
	MAP:	$+81.1 million, +15.6%
	ADM:	$ +0.7 million, + 5.0%

Tennessee has not begun deliberations on its FY 1987 budget. Consequently, an across the board 15.6 percent increase was applied to the current FY 1986 medical assistance payment estimate to produce the FY 1987 projection. This projection was based on the 15.7 percent historical annual average growth since FY 1982.

Adminstration estimates reflect a slight growth for salary increases and normal inflation.

EXPLANATION OF CHANGES IN STATE ESTIMATES GROWTH BETWEEN FY 1986 - 1987

MICHIGAN		
	Total:	$+76.2 million, +6.5%
	MAP:	$+74.1 million, +6.6%
	ADM:	$+ 2.1 million, +4.4%

Michigan's FY 1987 budget cycle has not yet started. The medical assistance payment estimate submitted by the State represents its projected FY 1986 medical assistance payments inflated by 6.6 percent across all service categories. Thus, it is not surprising that more than half ($41.4 million) of the projected growth falls in the three largest service categories: Inpatient Hospital, $22.4 million; Intermediate Care Facility (ICF)/All Other, $12.0 million; and ICF/Mentally Retarded, $7.3 million.

STATE TABLES

The following section consists of a series of State-specific tables showing:

1. Total computable costs by MAP and A&T (FY 1985-7)
2. Estimated grant awards FY 1985-7
3. Comparison between fiscal years 1985-86, and 1986-7 (by MAP and A&T)
4. Comparison between February and May estimates for FYs 1985 and 1986 (by MAP and A&T)

All tabular information shown at the State level is based on the unadjusted States' estimates.

STATE TABLES

Total Computable Medical Assistance Payments

(Dollars in Thousands)

	FY 1985	FY 1986	FY 1987
Alabama	$ 474,933	$ 438,278	$ 438,278
Alaska	63,011	72,167	81,652
American Samoa	2,969	2,969	2,969
Arizona	99,203	100,988	103,994
Arkansas	359,701	377,834	396,881
California	4,220,481	4,669,906	4,903,401
Colorado	316,187	339,900	368,793
Connecticut	579,191	637,960	703,581
Delaware	70,815	76,260	80,771
Dist. of Columbia	332,133	343,403	355,640
Florida	940,423	1,111,623	1,341,452
Georgia	760,982	835,022	888,731
Guam	3,400	3,400	3,400
Hawaii	138,412	140,295	140,353
Idaho	75,037	82,825	89,485
Illinois	1,720,965	1,820,340	1,863,000
Indiana	730,271	818,747	883,629
Iowa	348,826	362,540	384,491
Kansas	252,148	262,945	276,423
Kentucky	548,460	604,400	657,955
Louisiana	760,164	853,020	910,798
Maine	245,872	265,030	281,984
Maryland	646,900	728,924	794,527
Massachusetts	1,530,760	1,558,493	1,589,664
Massachusetts (Blind)	28,337	30,032	31,833
Michigan	1,819,143	1,992,033	2,122,580
Minnesota	1,019,072	1,123,766	1,198,895
Mississippi	294,206	324,130	342,468
Missouri	554,258	584,785	619,313
Montana	99,902	103,898	112,210
Nebraska	164,822	179,909	190,383
Nevada	78,619	84,187	88,513
New Hampshire	119,131	131,938	141,304
New Jersey	1,115,819	1,247,928	1,383,150
New Mexico	151,872	169,395	183,078

STATE TABLES

Total Computable Medical Assistance Payments

(Dollars in Thousands)

	FY 1985	FY 1986	FY 1987
New York	$ 7,846,724	$ 8,716,689	$ 9,614,396
North Carolina	630,656	678,514	746,367
North Dakota	110,512	132,138	137,378
N. Mariana Islands	925	950	970
Ohio	1,873,232	2,119,592	2,304,225
Oklahoma	443,878	481,569	544,595
Oregon	257,360	266,263	283,060
Pennsylvania	1,874,367	1,972,809	2,036,534
Puerto Rico	279,968	307,964	307,964
Rhode Island	251,129	272,308	288,869
South Carolina	350,547	439,149	488,601
South Dakota	92,730	98,691	108,053
Tennessee	641,545	737,776	848,442
Texas	1,519,508	1,742,778	1,916,981
Utah	149,800	171,000	182,206
Vermont	89,351	95,676	100,690
Virgin Islands	4,090	4,090	4,090
Virginia	571,662	603,984	632,036
Washington	607,791	650,743	690,810
West Virginia	177,993	183,158	188,713
Wisconsin	1,023,651	1,074,013	1,120,072
Wyoming	27,397	33,251	42,669
Totals	$ 39,491,241	$ 43,262,375	$ 46,543,300

STATE TABLES

Total Computable Administration

(Dollars in Thousands)

	FY 1985	FY 1986	FY 1987
Alabama	$ 15,460	$ 16,228	$ 17,520
Alaska	4,178	6,493	5,261
American Samoa	40	40	40
Arizona	6,565	9,784	10,108
Arkansas	15,545	16,166	14,425
California	288,999	293,233	307,895
Colorado	17,173	18,890	20,779
Connecticut	26,289	27,904	29,299
Delaware	3,211	3,233	3,310
Dist. of Columbia	16,069	17,230	17,919
Florida	39,174	59,016	85,567
Georgia	31,781	33,558	35,448
Guam	600	600	600
Hawaii	7,418	7,070	7,070
Idaho	4,740	4,526	4,672
Illinois	58,489	71,724	68,657
Indiana	26,567	29,144	32,109
Iowa	12,863	14,341	15,346
Kansas	12,593	13,193	13,673
Kentucky	24,790	27,105	26,545
Louisiana	26,327	27,837	28,483
Maine	12,036	12,765	13,530
Maryland	31,120	29,653	31,432
Massachusetts	50,415	53,130	56,219
Massachusetts (Blind)	758	802	802
Michigan	72,470	75,641	79,028
Minnesota	37,945	41,508	44,338
Mississippi	9,588	11,846	12,389
Missouri	19,170	20,326	21,078
Montana	7,185	5,405	4,871
Nebraska	10,832	11,310	11,737
Nevada	5,330	5,330	5,330
New Hampshire	8,380	8,966	8,888
New Jersey	57,805	67,738	77,217
New Mexico	9,477	8,801	9,134

STATE TABLES

Total Computable Administration

(Dollars in Thousands)

	FY 1985	FY 1986	FY 1987
New York	$ 389,041	$ 415,200	$ 436,900
North Carolina	35,953	35,403	36,248
North Dakota	6,093	6,422	6,728
N. Mariana Islands	109	120	130
Ohio	59,782	70,373	73,538
Oklahoma	35,494	36,529	38,355
Oregon	32,217	35,489	36,698
Pennsylvania	111,641	120,173	126,626
Puerto Rico	8,000	8,750	8,750
Rhode Island	7,172	7,602	8,058
South Carolina	21,390	23,160	24,550
South Dakota	2,632	2,755	2,892
Tennessee	31,980	25,764	27,052
Texas	108,887	123,278	122,787
Utah	14,900	16,400	16,974
Vermont	8,859	8,301	8,985
Virgin Islands	588	588	588
Virginia	23,901	23,325	24,738
Washington	29,759	30,692	31,352
West Virginia	11,113	11,185	11,968
Wisconsin	31,087	32,019	32,979
Wyoming	1,244	1,281	1,316
Totals	$ 1,943,224	$ 2,085,345	$ 2,198,931

STATE TABLES

Grant Award Estimates1/

(Dollars in Thousands)

	FY 1985 Appropriation Estimate	FY 1986 Appropriation Estimate	FY 1987 Appropriation Estimate
Alabama	$ 365,916	$ 329,421	$ 330,308
Alaska	34,680	42,687	46,516
American Samoa	1,150	1,150	1,150
Arizona	65,039	67,786	69,820
Arkansas	286,819	289,811	302,187
California	2,366,214	2,521,877	2,648,119
Colorado	170,115	183,253	199,015
Connecticut	306,295	336,631	370,405
Delaware	39,333	40,508	42,848
Dist. of Columbia	175,435	182,013	188,554
Florida	573,764	660,162	802,569
Georgia	552,984	573,016	609,687
Guam	2,000	2,000	2,000
Hawaii	74,536	76,616	76,652
Idaho	55,900	60,492	65,188
Illinois	941,578	959,169	977,962
Indiana	454,039	532,235	574,802
Iowa	202,855	22,975	236,630
Kansas	140,868	140,516	147,611
Kentucky	406,369	443,554	480,603
Louisiana	506,104	561,947	599,244
Maine	181,474	190,604	202,776
Maryland	344,230	383,305	417,278
Massachusetts	804,956	812,020	829,667
Mass. (Blind)	14,310	15,418	16,360
Michigan	971,814	1,179,396	1,255,714
Minnesota	560,372	626,463	668,439
Mississippi	237,681	262,573	277,343
Missouri	369,351	367,743	389,225
Montana	69,684	72,889	77,900
Nebraska	104,884	110,084	116,364
Nevada	43,567	45,064	47,232
New Hampshire	77,722	78,599	83,580
New Jersey	612,598	673,461	746,382
New Mexico	112,718	122,543	132,178
New York	4,168,059	4,619,072	5,080,519
North Carolina	461,716	489,666	536,978
North Dakota	72,017	77,474	80,580
N. Mariana Island	522	542	560
Ohio	1,082,223	1,286,459	1,395,356

STATE TABLES

Grant Award Estimates 1/

(Dollars in Thousands)

	FY 1985 Appropriation 2/ Estimate	FY 1986 Appropriation Estimate	FY 1987 Appropriation Estimate
Oklahoma	$ 292,131	$ 298,676	$ 336,211
Oregon	173,982	185,385	196,626
Pennsylvania	1,138,418	1,194,849	1,234,840
Puerto Rico	63,400	63,400	63,400
Rhode Island	150,260	157,716	167,313
South Carolina	282,303	335,390	372,390
South Dakota	65,953	70,339	76,928
Tennessee	493,597	534,278	616,149
Texas	938,224	1,015,787	1,108,192
Utah	115,569	134,533	143,046
Vermont	69,934	69,632	73,506
Virginia	350,699	334,160	349,867
Virgin Islands	2,325	2,466	2,497
Washington	334,417	346,543	367,126
West Virginia	136,736	138,511	143,016
Wisconsin	630,659	641,190	668,651
Wyoming	14,556	17,861	22,276
Subtotal	$ 23,265,212	$ 25,181,910	$ 27,068,335
Fraud Control Units	28,494	42,931	44,153
	23,293,706	25,224,841	27,112,488

1/ Amounts by State reflect combined total of Medical Assistance Payments, State and Local Administration and State Survey and Certification.

2/ The FY 1985 estimates also include FY 1984 incentive rebate payments to those States that qualified, as well as any adjustments made in FY 1985 to the FY 1982 and FY 1983 incentive rebates.

MEDICAL ASSISTANCE PAYMENTS - STATE TABLES
COMPARISON OF THE FISCAL YEARS 1985 TO 1986
MAY 1985 SUBMISSION
(DOLLARS IN THOUSANDS)

	1985 ESTIMATES	1986 ESTIMATES	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
ALABAMA	$ 343,864	$ 318,008	$ -25,856	-7.52
ALASKA	32,801	38,344	5,543	16.90
AMERICAN SAMOA	1,150	1,150	0	0.00
ARIZONA	61,756	62,894	1,138	1.84
ARKANSAS	264,920	278,955	14,035	5.30
CALIFORNIA	2,118,302	2,342,564	224,262	10.59
COLORADO	158,340	169,950	11,610	7.33
CONNECTICUT	290,410	319,877	29,467	10.15
DELAWARE	35,882	38,609	2,727	7.60
DISTRICT OF COLUMBIA	166,066	171,702	5,636	3.39
FLORIDA	549,198	624,287	75,089	13.67
GEORGIA	513,913	552,370	38,457	7.48
GUAM	1,700	1,700	0	0.00
HAWAII	69,654	71,993	2,339	3.36
IDAHO	50,583	57,530	6,947	13.73
ILLINOIS	865,422	914,970	49,548	5.73
INDIANA	438,021	514,338	76,317	17.42
IOWA	192,657	213,536	20,879	10.84
KANSAS	128,401	131,923	3,522	2.74
KENTUCKY	387,870	424,470	36,600	9.44
LOUISIANA	489,827	544,329	54,502	11.13
MAINE	173,783	182,499	8,716	5.02
MARYLAND	326,247	365,483	39,236	12.03
MASSACHUSETTS	767,533	779,248	11,715	1.53
MASSACHUSETTS (BLIND)	14,205	15,016	811	5.71
MICHIGAN	924,611	1,131,276	206,665	22.35
MINNESOTA	537,657	601,215	63,558	11.82
MISSISSIPPI	228,753	254,553	25,800	11.28
MISSOURI	341,163	355,364	14,201	4.16
MONTANA	64,720	69,388	4,668	7.21
NEBRASKA	94,294	102,907	8,613	9.13
NEVADA	39,427	42,094	2,667	6.76
NEW HAMPSHIRE	70,868	72,496	1,628	2.30
NEW JERSEY	559,883	626,014	66,131	11.81
NEW MEXICO	106,005	116,781	10,776	10.17
NEW YORK	3,936,415	4,369,411	432,996	11.00
NORTH CAROLINA	439,217	469,532	30,315	6.90
NORTH DAKOTA	68,214	73,359	5,145	7.54
NORTHERN MARIANA ISLANDS	463	476	13	2.81
OHIO	1,045,641	1,243,113	197,472	18.89
OKLAHOMA	259,732	277,384	17,652	6.80
OREGON	147,393	164,098	16,705	11.33

MEDICAL ASSISTANCE PAYMENTS - STATE TABLES
COMPARISON OF THE FISCAL YEARS 1985 TO 1986
MAY 1985 SUBMISSION
(DOLLARS IN THOUSANDS)

	1985 ESTIMATES	1986 ESTIMATES	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
PENNSYLVANIA	$ 1,053,413	$ 1,121,805	$ 68,392	6.49
PUERTO RICO	59,400	59,025	-375	-0.63
RHODE ISLAND	146,157	153,400	7,243	4.96
SOUTH CAROLINA	258,143	320,462	62,319	24.14
SOUTH DAKOTA	63,891	67,998	4,107	6.43
TENNESSEE	453,627	518,847	65,220	14.38
TEXAS	828,869	936,176	107,307	12.95
UTAH	106,118	124,180	18,062	17.02
VERMONT	61,983	64,160	2,177	3.51
VIRGIN ISLANDS	1,806	1,806	0	0.00
VIRGINIA	323,579	320,956	-2,623	-0.81
WASHINGTON	305,401	327,501	22,100	7.24
WEST VIRGINIA	125,642	131,012	5,370	4.27
WISCONSIN	584,611	620,409	35,798	6.12
WYOMING	13,786	16,958	3,172	23.01
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	$ 21,693,387	$ 23,889,901	$ 2,196,514	10.13

ADMINISTRATION PAYMENTS - STATE TABLES
COMPARISON OF THE FISCAL YEARS 1985 TO 1986
MAY 1985 SUBMISSION
(DOLLARS IN THOUSANDS)

	1985 ESTIMATES	1986 ESTIMATES	DIFFERENCE	
			AMOUNT	PERCENT
ALABAMA	$ 10,525	$ 10,926	$ 401	3.81
ALASKA	2,288	4,272	1,984	86.71
AMERICAN SAMOA	0	0	0	0.00
ARIZONA	3,283	4,892	1,609	49.01
ARKANSAS	9,645	10,218	573	5.94
CALIFORNIA	172,229	174,852	2,623	1.52
COLORADO	11,179	12,297	1,118	10.00
CONNECTICUT	14,943	15,780	837	5.60
DELAWARE	1,802	1,804	2	0.11
DISTRICT OF COLUMBIA	9,319	10,081	762	8.18
FLORIDA	23,379	34,670	11,291	48.30
GEORGIA	18,649	19,671	1,022	5.48
GUAM	300	300	0	0.00
HAWAII	4,803	4,535	-268	-5.58
IDAHO	3,125	2,883	-242	-7.74
ILLINOIS	34,933	42,336	7,403	21.19
INDIANA	15,307	16,778	1,471	9.61
IOWA	8,064	8,809	745	9.24
KANSAS	7,522	7,880	358	4.76
KENTUCKY	17,399	18,476	1,077	6.19
LOUISIANA	15,843	16,911	1,068	6.74
MAINE	7,214	7,640	426	5.91
MARYLAND	17,650	17,404	-246	-1.39
MASSACHUSETTS	28,945	31,554	2,609	9.01
MASSACHUSETTS (BLIND)	381	402	21	5.51
MICHIGAN	44,865	46,803	1,938	4.32
MINNESOTA	21,412	23,507	2,095	9.78
MISSISSIPPI	6,138	7,485	1,347	21.95
MISSOURI	10,690	11,278	588	5.50
MONTANA	4,847	3,368	-1,479	-30.51
NEBRASKA	6,313	6,585	272	4.31
NEVADA	2,909	2,909	0	0.00
NEW HAMPSHIRE	5,342	5,909	567	10.61
NEW JERSEY	41,318	46,745	5,427	13.13
NEW MEXICO	6,122	5,467	-655	-10.70
NEW YORK	228,986	244,860	15,874	6.93
NORTH CAROLINA	20,202	19,539	-663	-3.28
NORTH DAKOTA	3,539	3,800	261	7.37
NORTHERN MARIANA ISLANDS	59	66	7	11.86
OHIO	35,304	41,247	5,943	16.83
OKLAHOMA	19,659	20,622	963	4.90
OREGON	19,234	20,925	1,691	8.79

ADMINISTRATION PAYMENTS - STATE TABLES
COMPARISON OF THE FISCAL YEARS 1985 TO 1986
MAY 1985 SUBMISSION
(DOLLARS IN THOUSANDS)

	1985 ESTIMATES	1986 ESTIMATES	DIFFERENCE	
			AMOUNT	PERCENT
PENNSYLVANIA	$ 66,257	$ 71,210	$ 4,953	7.48
PUERTO RICO	4,000	4,375	375	9.38
RHODE ISLAND	3,792	4,017	225	5.93
SOUTH CAROLINA	13,299	14,400	1,101	8.28
SOUTH DAKOTA	1,652	1,730	78	4.72
TENNESSEE	21,754	14,644	-7,110	-32.68
TEXAS	67,319	75,633	8,314	12.35
UTAH	9,142	10,064	922	10.09
VERMONT	5,795	5,306	-489	-8.44
VIRGIN ISLANDS	294	294	0	0.00
VIRGINIA	13,530	13,204	-326	-2.41
WASHINGTON	18,429	18,468	39	0.21
WEST VIRGINIA	7,156	7,202	46	0.64
WISCONSIN	18,926	19,493	567	3.00
WYOMING	653	672	19	2.91
	$ 1,167,664	$ 1,247,198	$ 79,534	6.81

MEDICAL ASSISTANCE PAYMENTS - STATE TABLES
COMPARISON OF THE FISCAL YEARS 1986 TO 1987
MAY 1985 SUBMISSION
(DOLLARS IN THOUSANDS)

	1986 ESTIMATES	1987 ESTIMATES	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
ALABAMA	$ 318,008	$ 318,008	$ 0	0.00
ALASKA	38,344	43,467	5,123	13.36
AMERICAN SAMOA	1,150	1,150	0	0.00
ARIZONA	62,894	64,767	1,873	2.98
ARKANSAS	278,955	293,017	14,062	5.04
CALIFORNIA	2,342,564	2,459,692	117,128	5.00
COLORADO	169,950	184,397	14,447	8.50
CONNECTICUT	319,877	352,780	32,903	10.29
DELAWARE	38,609	40,893	2,284	5.92
DISTRICT OF COLUMBIA	171,702	177,820	6,118	3.56
FLORIDA	624,287	753,359	129,072	20.68
GEORGIA	552,370	587,869	35,499	6.43
GUAM	1,700	1,700	0	0.00
HAWAII	71,993	72,022	29	0.04
IDAHO	57,530	62,152	4,622	8.03
ILLINOIS	914,970	936,000	21,030	2.30
INDIANA	514,338	555,095	40,757	7.92
IOWA	213,536	226,465	12,929	6.05
KANSAS	131,923	138,690	6,767	5.13
KENTUCKY	424,470	462,082	37,612	8.86
LOUISIANA	544,329	581,199	36,870	6.77
MAINE	182,499	194,174	11,675	6.40
MARYLAND	365,483	398,376	32,893	9.00
MASSACHUSETTS	779,248	794,832	15,584	2.00
MASSACHUSETTS (BLIND)	15,016	15,958	942	6.27
MICHIGAN	1,131,276	1,205,413	74,137	6.55
MINNESOTA	601,215	641,409	40,194	6.69
MISSISSIPPI	254,553	268,957	14,404	5.66
MISSOURI	355,364	376,348	20,984	5.90
MONTANA	69,388	74,921	5,533	7.97
NEBRASKA	102,907	108,889	5,982	5.81
NEVADA	42,094	44,256	2,162	5.14
NEW HAMPSHIRE	72,496	77,643	5,147	7.10
NEW JERSEY	626,014	693,716	67,702	10.81
NEW MEXICO	116,781	126,214	9,433	8.08
NEW YORK	4,369,411	4,818,928	449,517	10.29
NORTH CAROLINA	469,532	516,486	46,954	10.00
NORTH DAKOTA	73,359	76,247	2,888	3.94
NORTHERN MARIANA ISLANDS	476	485	9	1.89
OHIO	1,243,113	1,351,398	108,285	8.71
OKLAHOMA	277,384	313,687	36,303	13.09
OREGON	164,098	174,619	10,521	6.41

MEDICAL ASSISTANCE PAYMENTS - STATE TABLES
COMPARISON OF THE FISCAL YEARS 1986 TO 1987
MAY 1985 SUBMISSION
(DOLLARS IN THOUSANDS)

	1986 ESTIMATES	1987 ESTIMATES	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
PENNSYLVANIA	$ 1,121,805	$ 1,158,059	$ 36,254	3.23
PUERTO RICO	59,025	59,025	0	0.00
RHODE ISLAND	153,400	162,729	9,329	6.08
SOUTH CAROLINA	320,462	356,552	36,090	11.26
SOUTH DAKOTA	67,998	74,449	6,451	9.49
TENNESSEE	518,847	599,920	81,073	15.63
TEXAS	936,176	1,029,641	93,465	9.98
UTAH	124,180	132,318	8,138	6.55
VERMONT	64,160	67,523	3,363	5.24
VIRGIN ISLANDS	1,806	1,806	0	0.00
VIRGINIA	320,956	335,864	14,908	4.64
WASHINGTON	327,501	347,631	20,130	6.15
WEST VIRGINIA	131,012	134,986	3,974	3.03
WISCONSIN	620,409	647,178	26,769	4.31
WYOMING	16,958	21,335	4,377	25.81
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	$ 23,889,901	$ 25,714,596	$ 1,824,695	7.64

ADMINISTRATION PAYMENTS - STATE TABLES
COMPARISON OF THE FISCAL YEARS 1986 TO 1987
MAY 1985 SUBMISSION
(DOLLARS IN THOUSANDS)

	1986 ESTIMATES	1987 ESTIMATES	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
ALABAMA	$ 10,926	$ 11,771	$ 845	7.73
ALASKA	4,272	2,972	-1,300	-30.43
AMERICAN SAMOA	0	0	0	0.00
ARIZONA	4,892	5,053	161	3.29
ARKANSAS	10,218	8,479	-1,739	-17.02
CALIFORNIA	174,852	183,589	8,737	5.00
COLORADO	12,297	13,527	1,230	10.00
CONNECTICUT	15,780	16,568	788	4.99
DELAWARE	1,804	1,852	48	2.66
DISTRICT OF COLUMBIA	10,081	10,484	403	4.00
FLORIDA	34,670	47,903	13,233	38.17
GEORGIA	19,671	20,760	1,089	5.54
GUAM	300	300	0	0.00
HAWAII	4,535	4,535	0	0.00
IDAHO	2,883	2,951	68	2.36
ILLINOIS	42,336	39,941	-2,395	-5.66
INDIANA	16,778	18,494	1,716	10.23
IOWA	8,809	9,481	672	7.63
KANSAS	7,880	8,148	268	3.40
KENTUCKY	18,476	17,861	-615	-3.33
LOUISIANA	16,911	17,278	367	2.17
MAINE	7,640	8,098	458	5.99
MARYLAND	17,404	18,448	1,044	6.00
MASSACHUSETTS	31,554	33,514	1,960	6.21
MASSACHUSETTS (BLIND)	402	402	0	0.00
MICHIGAN	46,803	48,873	2,070	4.42
MINNESOTA	23,507	25,142	1,635	6.96
MISSISSIPPI	7,485	7,805	320	4.28
MISSOURI	11,278	11,683	405	3.59
MONTANA	3,368	2,834	-534	-15.86
NEBRASKA	6,585	6,833	248	3.77
NEVADA	2,909	2,909	0	0.00
NEW HAMPSHIRE	5,909	5,727	-182	-3.08
NEW JERSEY	46,745	51,905	5,160	11.04
NEW MEXICO	5,467	5,644	177	3.24
NEW YORK	244,860	256,385	11,525	4.71
NORTH CAROLINA	19,539	19,847	308	1.58
NORTH DAKOTA	3,800	3,992	192	5.05
NORTHERN MARIANA ISLANDS	66	75	9	13.64
OHIO	41,247	41,681	434	1.05
OKLAHOMA	20,622	21,798	1,176	5.70
OREGON	20,925	21,615	690	3.30

ADMINISTRATION PAYMENTS - STATE TABLES
COMPARISON OF THE FISCAL YEARS 1986 TO 1987
MAY 1985 SUBMISSION
(DOLLARS IN THOUSANDS)

	1986 ESTIMATES	1987 ESTIMATES	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
PENNSYLVANIA	$ 71,210	$ 74,792	$ 3,582	5.03
PUERTO RICO	4,375	4,375	0	0.00
RHODE ISLAND	4,017	4,260	243	6.05
SOUTH CAROLINA	14,400	15,265	865	6.01
SOUTH DAKOTA	1,730	1,816	86	4.97
TENNESSEE	14,644	15,376	732	5.00
TEXAS	75,633	74,236	-1,397	-1.85
UTAH	10,064	10,415	351	3.49
VERMONT	5,306	5,803	497	9.37
VIRGIN ISLANDS	294	294	0	0.00
VIRGINIA	13,204	14,003	799	6.05
WASHINGTON	18,468	18,872	404	2.19
WEST VIRGINIA	7,202	7,708	506	7.03
WISCONSIN	19,493	20,076	583	2.99
WYOMING	672	690	18	2.68
	$ 1,247,198	$ 1,305,138	$ 57,940	4.65

COMPARISON OF STATE ESTIMATES
MEDICAL ASSISTANCE PAYMENTS
FEBRUARY 1985 SUBMISSION TO MAY 1985 SUBMISSION
FISCAL YEAR 1985
(DOLLARS IN THOUSANDS)

	FEBRUARY 1985 SUBMISSION	MAY 1985 SUBMISSION	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
ALABAMA	$ 350,843	$ 343,864	$ -6,979	-1.99
ALASKA	35,246	32,801	-2,445	-6.94
AMERICAN SAMOA	1,150	1,150	0	0.00
ARIZONA	59,207	61,756	2,549	4.31
ARKANSAS	264,920	264,920	0	0.00
CALIFORNIA	2,073,787	2,118,302	44,515	2.15
COLORADO	159,936	158,340	-1,596	-1.00
CONNECTICUT	290,410	290,410	0	0.00
DELAWARE	37,364	35,882	-1,482	-3.97
DISTRICT OF COLUMBIA	167,753	166,066	-1,687	-1.01
FLORIDA	565,363	549,198	-16,165	-2.86
GEORGIA	526,300	513,913	-12,387	-2.35
GUAM	1,700	1,700	0	0.00
HAWAII	69,017	69,654	637	0.92
IDAHO	50,466	50,583	117	0.23
ILLINOIS	842,910	865,422	22,512	2.67
INDIANA	420,868	438,021	17,153	4.08
IOWA	192,657	192,657	0	0.00
KANSAS	127,188	128,401	1,213	0.95
KENTUCKY	379,464	387,870	8,406	2.22
LOUISIANA	495,507	489,827	-5,680	-1.15
MAINE	169,697	173,783	4,086	2.41
MARYLAND	337,330	326,247	-11,083	-3.29
MASSACHUSETTS	768,593	767,533	-1,060	-0.14
MASSACHUSETTS (BLIND)	14,443	14,205	-238	-1.65
MICHIGAN	947,864	924,611	-23,253	-2.45
MINNESOTA	548,128	537,657	-10,471	-1.91
MISSISSIPPI	238,721	228,753	-9,968	-4.18
MISSOURI	341,915	341,163	-752	-0.22
MONTANA	64,789	64,720	-69	-0.11
NEBRASKA	93,810	94,294	484	0.52
NEVADA	39,427	39,427	0	0.00
NEW HAMPSHIRE	68,453	70,868	2,415	3.53
NEW JERSEY	591,188	559,883	-31,305	-5.30
NEW MEXICO	104,522	106,005	1,483	1.42
NEW YORK	4,021,053	3,936,415	-84,638	-2.10
NORTH CAROLINA	454,870	439,217	-15,653	-3.44
NORTH DAKOTA	69,596	68,214	-1,382	-1.99
NORTHERN MARIANA ISLANDS	440	463	23	5.23
OHIO	1,081,049	1,045,641	-35,408	-3.28
OKLAHOMA	260,168	259,732	-436	-0.17
OREGON	142,756	147,393	4,637	3.25

COMPARISON OF STATE ESTIMATES
MEDICAL ASSISTANCE PAYMENTS
FEBRUARY 1985 SUBMISSION TO MAY 1985 SUBMISSION
FISCAL YEAR 1985
(DOLLARS IN THOUSANDS)

	FEBRUARY 1985 SUBMISSION	MAY 1985 SUBMISSION	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
PENNSYLVANIA	$ 1,039,647	$ 1,053,413	$ 13,766	1.32
PUERTO RICO	59,400	59,400	0	0.00
RHODE ISLAND	144,800	146,157	1,357	0.94
SOUTH CAROLINA	267,006	258,143	-8,863	-3.32
SOUTH DAKOTA	62,832	63,891	1,059	1.69
TENNESSEE	538,445	453,627	-84,818	-15.75
TEXAS	866,011	828,869	-37,142	-4.29
UTAH	109,094	106,118	-2,976	-2.73
VERMONT	62,485	61,983	-502	-0.80
VIRGIN ISLANDS	1,806	1,806	0	0.00
VIRGINIA	332,786	323,579	-9,207	-2.77
WASHINGTON	302,348	305,401	3,053	1.01
WEST VIRGINIA	120,214	125,642	5,428	4.52
WISCONSIN	585,351	584,611	-740	-0.13
WYOMING	13,786	13,786	0	0.00
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	$ 21,976,879	$ 21,693,387	$ -283,492	-1.29

COMPARISON OF STATE ESTIMATES
ADMINISTRATION PAYMENTS
FEBRUARY 1985 SUBMISSION TO MAY 1985 SUBMISSION
FISCAL YEAR 1985
(DOLLARS IN THOUSANDS)

	FEBRUARY 1985 SUBMISSION	MAY 1985 SUBMISSION	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
ALABAMA	$ 10,277	$ 10,525	$ 248	2.41
ALASKA	2,281	2,288	7	0.31
AMERICAN SAMOA	0	0	0	0.00
ARIZONA	1,972	3,283	1,311	66.48
ARKANSAS	9,667	9,645	-22	-0.23
CALIFORNIA	154,895	172,229	17,334	11.19
COLORADO	11,614	11,179	-435	-3.75
CONNECTICUT	14,352	14,943	591	4.12
DELAWARE	1,769	1,802	33	1.87
DISTRICT OF COLUMBIA	9,387	9,319	-68	-0.72
FLORIDA	26,471	23,379	-3,092	-11.68
GEORGIA	15,669	18,649	2,980	19.02
GUAM	300	300	0	0.00
HAWAII	5,064	4,803	-261	-5.15
IDAHO	3,233	3,125	-108	-3.34
ILLINOIS	37,113	34,933	-2,180	-5.87
INDIANA	15,412	15,307	-105	-0.68
IOWA	7,834	8,064	230	2.94
KANSAS	7,270	7,522	252	3.47
KENTUCKY	16,285	17,399	1,114	6.84
LOUISIANA	16,355	15,843	-512	-3.13
MAINE	6,853	7,214	361	5.27
MARYLAND	17,684	17,650	-34	-0.19
MASSACHUSETTS	27,629	28,945	1,316	4.76
MASSACHUSETTS (BLIND)	374	381	7	1.87
MICHIGAN	44,865	44,865	0	0.00
MINNESOTA	21,370	21,412	42	0.20
MISSISSIPPI	5,851	6,138	287	4.91
MISSOURI	10,618	10,690	72	0.68
MONTANA	4,847	4,847	0	0.00
NEBRASKA	6,269	6,313	44	0.70
NEVADA	2,841	2,909	68	2.39
NEW HAMPSHIRE	5,317	5,342	25	0.47
NEW JERSEY	41,265	41,318	53	0.13
NEW MEXICO	5,871	6,122	251	4.28
NEW YORK	215,225	228,986	13,761	6.39
NORTH CAROLINA	20,373	20,202	-171	-0.84
NORTH DAKOTA	3,470	3,539	69	1.99
NORTHERN MARIANA ISLANDS	63	59	-4	-6.35
OHIO	33,550	35,304	1,754	5.23
OKLAHOMA	19,544	19,659	115	0.59
OREGON	18,878	19,234	356	1.89

COMPARISON OF STATE ESTIMATES
ADMINISTRATION PAYMENTS
FEBRUARY 1985 SUBMISSION TO MAY 1985 SUBMISSION
FISCAL YEAR 1985
(DOLLARS IN THOUSANDS)

	FEBRUARY 1985 SUBMISSION	MAY 1985 SUBMISSION	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
PENNSYLVANIA	$ 66,078	$ 66,257	$ 179	0.27
PUERTO RICO	4,000	4,000	0	0.00
RHODE ISLAND	3,682	3,792	110	2.99
SOUTH CAROLINA	12,957	13,299	342	2.64
SOUTH DAKOTA	1,668	1,652	-16	-0.96
TENNESSEE	20,467	21,754	1,287	6.29
TEXAS	70,105	67,319	-2,786	-3.97
UTAH	9,518	9,142	-376	-3.95
VERMONT	5,723	5,795	72	1.26
VIRGIN ISLANDS	294	294	0	0.00
VIRGINIA	13,759	13,530	-229	-1.66
WASHINGTON	18,898	18,429	-469	-2.48
WEST VIRGINIA	6,626	7,156	530	8.00
WISCONSIN	19,530	18,926	-604	-3.09
WYOMING	653	653	0	0.00
	$ 1,133,935	$ 1,167,664	$ 33,729	2.97

COMPARISON OF STATE ESTIMATES
MEDICAL ASSISTANCE PAYMENTS
FEBRUARY 1985 SUBMISSION TO MAY 1985 SUBMISSION
FISCAL YEAR 1986
(DOLLARS IN THOUSANDS)

	FEBRUARY 1985 SUBMISSION	MAY 1985 SUBMISSION	DIFFERENCE	
			AMOUNT	PERCENT
ALABAMA	$ 317,831	$ 318,008	$ 177	0.06
ALASKA	43,957	38,344	-5,613	-12.77
AMERICAN SAMOA	1,150	1,150	0	0.00
ARIZONA	61,085	62,894	1,809	2.96
ARKANSAS	278,955	278,955	0	0.00
CALIFORNIA	2,209,230	2,342,564	133,334	6.04
COLORADO	175,863	169,950	-5,913	-3.36
CONNECTICUT	319,877	319,877	0	0.00
DELAWARE	40,806	38,609	-2,197	-5.38
DISTRICT OF COLUMBIA	166,466	171,702	5,236	3.15
FLORIDA	658,173	624,287	-33,886	-5.15
GEORGIA	562,318	552,370	-9,948	-1.77
GUAM	1,700	1,700	0	0.00
HAWAII	71,027	71,993	966	1.36
IDAHO	58,910	57,530	-1,380	-2.34
ILLINOIS	914,970	914,970	0	0.00
INDIANA	467,255	514,338	47,083	10.08
IOWA	216,760	213,536	-3,224	-1.49
KANSAS	133,595	131,923	-1,672	-1.25
KENTUCKY	407,626	424,470	16,844	4.13
LOUISIANA	544,329	544,329	0	0.00
MAINE	178,357	182,499	4,142	2.32
MARYLAND	365,483	365,483	0	0.00
MASSACHUSETTS	766,510	779,248	12,738	1.66
MASSACHUSETTS (BLIND)	15,016	15,016	0	0.00
MICHIGAN	1,176,464	1,131,276	-45,188	-3.84
MINNESOTA	612,945	601,215	-11,730	-1.91
MISSISSIPPI	298,491	254,553	-43,938	-14.72
MISSOURI	368,787	355,364	-13,423	-3.64
MONTANA	67,365	69,388	2,023	3.00
NEBRASKA	98,403	102,907	4,504	4.58
NEVADA	42,073	42,094	21	0.05
NEW HAMPSHIRE	71,609	72,496	887	1.24
NEW JERSEY	642,305	626,014	-16,291	-2.54
NEW MEXICO	115,516	116,781	1,265	1.10
NEW YORK	4,501,795	4,369,411	-132,384	-2.94
NORTH CAROLINA	504,588	469,532	-35,056	-6.95
NORTH DAKOTA	67,880	73,359	5,479	8.07
NORTHERN MARIANA ISLANDS	462	476	14	3.03
OHIO	1,210,833	1,243,113	32,280	2.67
OKLAHOMA	268,484	277,384	8,900	3.31
OREGON	162,375	164,098	1,723	1.06

COMPARISON OF STATE ESTIMATES
MEDICAL ASSISTANCE PAYMENTS
FEBRUARY 1985 SUBMISSION TO MAY 1985 SUBMISSION
FISCAL YEAR 1986
(DOLLARS IN THOUSANDS)

	FEBRUARY 1985 SUBMISSION	MAY 1985 SUBMISSION	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
PENNSYLVANIA	$ 1,109,486	$ 1,121,805	$ 12,319	1.11
PUERTO RICO	59,025	59,025	0	0.00
RHODE ISLAND	147,866	153,400	5,534	3.74
SOUTH CAROLINA	294,598	320,462	25,864	8.78
SOUTH DAKOTA	66,314	67,998	1,684	2.54
TENNESSEE	568,710	518,847	-49,863	-8.77
TEXAS	983,169	936,176	-46,993	-4.78
UTAH	122,002	124,180	2,178	1.79
VERMONT	62,014	64,160	2,146	3.46
VIRGIN ISLANDS	1,806	1,806	0	0.00
VIRGINIA	346,182	320,956	-25,226	-7.29
WASHINGTON	329,308	327,501	-1,807	-0.55
WEST VIRGINIA	129,260	131,012	1,752	1.36
WISCONSIN	619,774	620,409	635	0.10
WYOMING	16,958	16,958	0	0.00
	$ 24,044,096	$ 23,889,901	$ -154,195	-0.64

COMPARISON OF STATE ESTIMATES
ADMINISTRATION PAYMENTS
FEBRUARY 1985 SUBMISSION TO MAY 1985 SUBMISSION
FISCAL YEAR 1986
(DOLLARS IN THOUSANDS)

	FEBRUARY 1985 SUBMISSION	MAY 1985 SUBMISSION	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
ALABAMA	$ 11,222	$ 10,926	$ -296	-2.64
ALASKA	4,301	4,272	-29	-0.67
AMERICAN SAMOA	0	0	0	0.00
ARIZONA	3,276	4,892	1,616	49.33
ARKANSAS	10,218	10,218	0	0.00
CALIFORNIA	150,836	174,852	24,016	15.92
COLORADO	12,357	12,297	-60	-0.49
CONNECTICUT	15,070	15,780	710	4.71
DELAWARE	1,782	1,804	22	1.23
DISTRICT OF COLUMBIA	9,861	10,081	220	2.23
FLORIDA	42,230	34,670	-7,560	-17.90
GEORGIA	15,733	19,671	3,938	25.03
GUAM	300	300	0	0.00
HAWAII	4,715	4,535	-180	-3.82
IDAHO	3,046	2,883	-163	-5.35
ILLINOIS	42,792	42,336	-456	-1.07
INDIANA	16,650	16,778	128	0.77
IOWA	8,596	8,809	213	2.48
KANSAS	7,315	7,880	565	7.72
KENTUCKY	17,235	18,476	1,241	7.20
LOUISIANA	16,749	16,911	162	0.97
MAINE	7,056	7,640	584	8.28
MARYLAND	17,404	17,404	0	0.00
MASSACHUSETTS	30,499	31,554	1,055	3.46
MASSACHUSETTS (BLIND)	402	402	0	0.00
MICHIGAN	47,018	46,803	-215	-0.46
MINNESOTA	23,507	23,507	0	0.00
MISSISSIPPI	5,633	7,485	1,852	32.88
MISSOURI	11,286	11,278	-8	-0.07
MONTANA	3,368	3,368	0	0.00
NEBRASKA	6,530	6,585	55	0.84
NEVADA	2,841	2,909	68	2.39
NEW HAMPSHIRE	5,852	5,909	57	0.97
NEW JERSEY	46,346	46,745	399	0.86
NEW MEXICO	5,226	5,467	241	4.61
NEW YORK	222,022	244,860	22,838	10.29
NORTH CAROLINA	19,339	19,539	200	1.03
NORTH DAKOTA	3,532	3,800	268	7.59
NORTHERN MARIANA ISLANDS	73	66	-7	-9.59
OHIO	36,905	41,247	4,342	11.77
OKLAHOMA	20,896	20,622	-274	-1.31
OREGON	19,612	20,925	1,313	6.69

COMPARISON OF STATE ESTIMATES
ADMINISTRATION PAYMENTS
FEBRUARY 1985 SUBMISSION TO MAY 1985 SUBMISSION
FISCAL YEAR 1986
(DOLLARS IN THOUSANDS)

	FEBRUARY 1985 SUBMISSION	MAY 1985 SUBMISSION	DIFFERENCE AMOUNT	DIFFERENCE PERCENT
PENNSYLVANIA	$ 71,364	$ 71,210	$ -154	-0.22
PUERTO RICO	4,375	4,375	0	0.00
RHODE ISLAND	3,926	4,017	91	2.32
SOUTH CAROLINA	14,394	14,400	6	0.04
SOUTH DAKOTA	1,746	1,730	-16	-0.92
TENNESSEE	18,775	14,644	-4,131	-22.00
TEXAS	72,025	75,633	3,608	5.01
UTAH	9,735	10,064	329	3.38
VERMONT	5,572	5,306	-266	-4.77
VIRGIN ISLANDS	294	294	0	0.00
VIRGINIA	13,472	13,204	-268	-1.99
WASHINGTON	18,202	18,468	266	1.46
WEST VIRGINIA	7,298	7,202	-96	-1.32
WISCONSIN	20,507	19,493	-1,014	-4.94
WYOMING	672	672	0	0.00
	$ 1,191,988	$ 1,247,198	$ 55,210	4.63

FY 1987

PAYMENTS TO THE HEALTH CARE TRUST FUNDS

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PAYMENTS TO HEALTH CARE TRUST FUNDS

(Dollars in Millions)

	FY 85	FY 86	FY 87 Request	Change From 86
Military Service Credits	$ 86	$ 91	$ 92	$ 1
Supplementary Medical Insurance	17,898	18,518	20,198	+1,680
Hospital Insurance for the Uninsured	762	554	568	+14
Federal Uninsured Payment	4	12	13	+1
Total Appropriation	$18,750	$ 19,175	$20,871	$ +1,696

- Military Service Credits - provides reimbursement to the Hospital Insurance Trust Fund (Part A) for the estimated employer and employee payroll tax that would have been received by the trust fund if certain non-pay compensation, to the armed forces, had been taxed. The estimate of $92 million is for calendar year 1987.

  An additional adjustment to the lump sum payment (made during May 1983 for benefit payments resulting from credits on wages paid before 1957) will be made during the first quarter of FY 1986, but at this time, there has been no determination made as to the amount required.

- Federal Payment for Supplementary Medical Insurance (SMI) - provides federal matching for premiums paid by Part B enrollees. The premiums and the federal contribution finance the benefits and the administrative costs of the SMI trust fund. During 1987, the monthly premium payment per enrollee will be $17.80 while the Federal payment will be $53.20 and $77.20 for the aged and the disabled, respectively.

  The request for FY 1987 of $20,198 million represents an increase of $1,680 million or 9.1 percent over FY 1985. This increase reflects projected increases in program outlays, reduced somewhat by increased interest payments and a lower contingency margin.

- Hospital Insurance for the Uninsured - provides reimbursement to the Hospital Insurance Trust Fund (Part A) to cover the cost of providing coverage to certain individuals who were grandfathered into the program.

  The request for FY 1987 is $568 million, which is $14 million or 2.5 percent higher than FY 1986. However, when you add the negative adjustment for prior year costs ($78 million) from FY 1986, the change becomes 10.1 percent lower than the previous year. That is, the decline in the number of uninsured from 359,000 to 306,000 offsets the increase in program costs for the remaining group due to inflation and higher utilization.

- Federal Uninsured Payment - When the Social Security Act was amended by P.L. 97-248 to extend Medicare coverage to Civil Service annuitants, a transitional provision was created for individuals who had worked for the Federal government prior to 1983 and who are employed during January 1983. The provision allows these individuals to receive credit toward Medicare coverage for noncontributory quarters worked in the Federal government.

  The amendment authorized an appropriation to the Hospital Insurance Trust Fund to cover the cost of: benefits to these indivuduals; associated administrative costs; and an interest payment that would put the trust fund in the same position at the end of the fiscal year as it would have been if transitional coverage were not available.

  The request for FY 1987 is $13 million an increase of $1 million over FY 1985, which reflects some leveling of application increases as Federal annuitants reach the age of eligibility and elect Medicare coverage.

FY 1987

MEDICARE BENEFITS

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MEDICARE BENEFITS

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Medicare Benefits Overview

Medicare benefits will total $80.4 billion during FY 1987, an increase of $6.6 billion or 9.0 percent over FY 1986. For this year, distortions of the increase which occurred throughout FY 1983-1986 period from the provision P.L. 97-248 to delay Periodic Interim Payments (PIP) at the end of FY 1983 and FY 1984 no longer apply.

Rate of Benefit Increase

	FY 85	FY 86	FY 87
Budgeted Benefits			
Part A	15.4	0.9	8.2
Part B	10.1	18.8	10.5
Total Medicare	13.7	6.5	9.0

The 9.0 percent for FY 1987 increase very close to the average increase on a normalized basis for the previous 3 years (9.3 percent).

The rate of growth for Part B continues to exceed that for Part A in total benefits outlays and average benefits per enrollee reimbursed. One way to compare program growth is to measure both against a common relevant standard, such as the published projection of the medical CPI (MCPI). Whereas total benefit outlays for Part A increase at 39 percent higher than the projected FY 1987 MCPI, Part B benefits are projected to increase at 78 percent higher. Part A increases are constrained within the Prospective Payment System (PPS) and an update assumption equal to the Market Basket. The difference in the growth rate between the program is expected to continue to have Part B exceed Part A, and for both to parallel changes in the MCPI after FY 1987.

The Medicare Rates of Increase charts show that there is a sudden drop in the rate of benefit increases in FY 1986 for Part A Benefits, both total and per enrollee reimbursed. The decline is due to a regulatory limit which constrains PPS payments to the same average rate as in FY 1985. The rise in the following year depicts a return toward more normal levels of increase using an update assumption at the hospital market basket (6.6 percent) plus utilization changes.

For Part B, the rates of increase appear high in FY 1986 compared to FY 1985. This upswing reflects an update of fees for participating physicians from the physician fee freeze during FY 1985 and an actuarial reestimates of cash lag effects. The lower level of increase in FY 1987 simply demonstrates a return to normal rates of increase for Part B benefits. This same pattern for FY 1986 and FY 1987 is reflected in the benefits per enrollee reimbursed.

The pattern for the aged and disabled populations over the FY 1985-FY 1987 period are closely aligned. These patterns reflect stabilization in the size and definition of the disabled population causing a more balanced use of the hospital and physician services by this group. The somewhat depressed level of increase in FY 1987 compared to the out-years show the small remaining reaction to the wide swings of previous years as the rates of increase stablize.

MEDICARE BENEFITS - HISTORIC OUTLAYS AND PROJECTIONS

(Dollars in Millions)

	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971	FY 1972	FY 1973	FY 1974	FY 1975	FY 1976	TQ 1976	FY 1977	FY 1978
HOSPITAL INSURANCE BENEFIT OUTLAYS	2,508	3,736	4,654	4,804	5,442	6,108	6,648	7,806	10,353	12,267	3,315	14,906	17,411
% CHANGE		49.0%	24.6%	3.2%	13.3%	12.2%	8.8%	17.4%	32.6%	18.5%	17.2%	16.7%	16.8%
SUPPLEMENTARY MEDICAL INSURANCE BENEFIT OUTLAYS	664	1,390	1,645	1,979	2,035	2,255	2,391	2,874	3,765	4,672	1,269	5,867	6,852
% CHANGE		109.3%	18.3%	20.3%	2.8%	10.8%	6.0%	20.2%	31.0%	24.1%	N/A	N/A	16.8%
TOTAL MEDICARE BENEFIT OUTLAYS	3,172	5,126	6,299	6,783	7,477	8,363	9,039	10,680	14,118	16,939	4,584	20,773	24,263
% CHANGE		61.6%	22.9%	7.7%	10.2%	11.0%	8.1%	18.2%	32.2%	20.0%	N/A	N/A	16.8%

	FY 1979	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
HOSPITAL INSURANCE BENEFIT OUTLAYS	19,891	23,790	28,907	34,343	38,102	41,461	47,064	48,314	52,254	57,931	64,096	70,696
PIP ADJUSTMENT					38,942	41,541	46,922					
% CHANGE	14.2%	19.6%	21.5%	18.8%	10.9%	20.7%	15.4%	0.9%	8.2%	10.9%	10.6%	10.3%
PIP ADJUSTMENT					13.1%	21.0%	13.0%	3.0%				
SUPPLEMENTARY MEDICAL INSURANCE BENEFIT OUTLAYS	8,259	10,144	12,345	14,806	17,487	19,475	21,436	25,464	28,139	31,753	35,796	40,395
% CHANGE	20.5%	22.8%	21.7%	19.9%	18.1%	11.4%	10.1%	18.8%	10.5%	12.8%	12.7%	12.8%
TOTAL MEDICARE BENEFIT OUTLAYS	28,150	33,934	41,252	49,149	55,589	60,936	69,300	73,778	80,393	89,684	99,892	111,091
PIP ADJUSTMENT					56,429	61,016	68,358					
% CHANGE	16.0%	20.5%	21.6%	19.1%	13.1%	9.6%	13.7%	6.5%	9.0%	11.6%	11.4%	11.2%
PIP ADJUSTMENT					14.8%	8.1%	12.0%	7.9%				

Hospital Insurance

Hospital Insurance benefits for FY 1987 are projected to be $52.3 billion, this is $3.9 billion or 8.2 percent higher than FY 1985.

Within Part A:

- o inpatient hospital services are projected to be $48.8 billion, an increase of 7.9 percent over FY 1986;
- o SNF services $720 million, an increase of 9.4 percent;
- o home health services will be $2.8 billion increasing at 13.7 percent; and
- o hospice services will be $8 million, down 73.3 percent for FY 1986 which gives the expected lag of bills after program termination.

The increase, for all Part A services, over FY 1986 is generally the result of: changes in hospital wages and inflation in goods and services used by health providers; growth in the enrollee population and the aging of that population; and changes in the provision and utilization of health care services. More specifically:

- o Upward changes in reimbursement per unit of service account for 64 percent of the total increase. Total reimbursement to hospitals will increase by 7.9 percent and by 9.4 percent and 13.7 percent to skilled nursing facilities and home health agencies respectively. The relatively new hospices should double their reimbursement.
- o Changes in enrollment account for 21.7 percent of the increase. The Part A enrollee population will increase from 30.9 million to 31.5 million or by 1.9 percent.
  - — While total enrollment grows by 1.9 percent, the number of enrollees receiving reimbursement will grow by 3.1 percent.
  - — Within the aged enrollee category, the insured population will grow by 2.4 percent, while the uninsured population will continue its decline, decreasing 14.1 percent in FY 1987.
  - — The trend toward growth in the disabled population ceased in FY 1982, and has declined each year since, except FY 1985 when it increased 0.7 percent. During FY 1987, that population is expected to decline by 1.0 percent.

- Finally, 9.8 percent of the increase is due to changes in admissions and days of care per capita. Admissions per capita are projected to remain nearly the same and days of care per capita will increase 0.8 percent for skilled nursing facilities and 5.6 percent for home health agencies.

In 1986 the sudden drop in the growth of benefits for both the aged and disabled from FY 1985 levels is primarily due to the assumed implementation of the zero limit on average DRG payments, and for restoration of normal cash flows (FY 1985 is assumed to be a 'catch-up' year for cash flows under prospective payment).

Benefits per enrollee receiving reimbursement will increase by 5.0 percent for aged and 4.8 percent for disabled which is slower than the industry inflation projections. The medical CPI is projected to increase by 5.9 percent and our Hospital Market Basket inflation at about 6.6 percent. Benefits per enrollee are projected to average $1,633 for the aged and $1,936 for the disabled. Since only 26.6 percent of all enrollees will receive reimbursement, average benefits per enrollee receiving reimbursement are much higher than average benefits per enrollee, $6,141 for aged and $7,147 for disabled.

Based on Spring Review assumptions, the outyear current law projections show the rate of HI program growth increasing slightly from 8.2 percent in FY 1987 to 10.3 percent by FY 1990. (Actuarial estimates for FY 1991 will be developed as part of the base reconstruction in December when economic assumptions are received.) Benefits in FY 1990 will be $70.7 billion, 32 percent higher than the FY 1987 estimate. The increases in the outyears will still be driven primarily by the hospital market basket and to lesser degree by enrollment and increases in admission per capita. Also, by FY 1990 the percentage of enrollees receiving reimbursement will be 27.3 percent as opposed to 26.6 percent in FY 1987.

The HI trust fund current law income in FY 1987 will be $69.3 billion, however excluding the repayment of the loan to OASI, the income will be $63.3 billion. This compares to total trust fund current law outlays, benefits and administration, of $58.2 billion. 1986 is the year of the last scheduled increase in the HI Payroll tax rate, it will increase from 1.35 percent in 1985 to 1.45 percent. This increase helps to keep income greater than outlays for the year. The tax increase, the effects of the Deficit Reduction Act of 1984 (DEFRA), plus long-term effects of regulatory constraints on payments in FY 1986 incorporated into current law help to keep outlays below income through 1990. The FY 1985 Trustees Report using Alternative IIB assumptions now reflects the depletion of the trust fund to occur in FY 1998.

The effect of FY 1986 regulations are projected savings of $2.1 billion in that year and $16.4 billion through FY 1990. Among these changes, the effect of maintaining DRG payment rates at the average FY 1985 level accounts for 77.6 percent of the savings with 16.5 additionally due to freezing payment for direct medical education.

Passage of the Social Security Disability Benefits Reform Act of 1984 had the effect of increasing the disabled population by encouraging appeals of termination decisions by allowing benefits to continue during appeal and requiring a demonstration that medical condition or technology has changed to allow a person to return to work before disenrolling of a beneficiary.

TABLE A1 - HISTORICAL MEDICARE PART A OUTLAYS BY SERVICE
(DOLLARS IN MILLIONS)

	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971	FY 1972	FY 1973	FY 1974	FY 1975	FY1976	TQ 1976	FY 1977
INPATIENT HOSPITAL	2,393	3,348	4,239	4,452	5,102	5,807	6,412	7,513	9,947	11,742	3,171	14,266
% CHANGE		39.9%	26.6%	5.0%	16.4%	13.8%	8.9%	17.2%	32.4%	18.0%	N/A	N/A
SKILLED NURSING FACILITIES	97	344	367	298	214	174	179	214	273	308	81	351
% CHANGE		254.6%	6.7%	-18.8%	-28.2%	-18.7%	2.9%	19.6%	27.6%	12.8%	N/A	N/A
HOME HEALTH	13	36	48	54	46	47	57	79	133	217	63	289
% CHANGE		176.9%	33.3%	12.5%	-14.8%	2.2%	21.3%	38.6%	68.4%	63.2%	N/A	N/A
OUTPATIENT	5	8										
% CHANGE		60.0%										
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TOTAL HOSPITAL INSURANCE BENEFITS	2,508	3,736	4,654	4,804	5,442	6,108	6,648	7,806	10,353	12,267	3,315	14,906
% CHANGE		49.0%	24.6%	3.2%	13.3%	12.2%	8.8%	17.4%	32.6%	18.5%	17.2%	16.7%

	FY 1978	FY 1979	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY1987	FY 1988	FY 1989	FY 1990
INPATIENT HOSPITAL	16,696	19,086	22,856	27,757	32,729	36,077	39,035	45,037	45,187	48,753	53,991	59,684	65,807
				PIP ADJUSTMENT		36,917	39,115	44,095					
% CHANGE	17.0%	14.3%	19.8%	21.4%	17.9%	10.2%	8.2%	15.4%	0.3%	7.9%	10.7%	10.5%	10.3%
				PIP ADJUSTMENT		12.8%	6.0%	12.7%	2.5%				
SKILLED NURSING FACILITIES	359	364	387	424	454	515	545	603	658	720	792	869	952
% CHANGE	0.9%	2.8%	6.3%	9.6%	7.1%	13.4%	20.0%	10.6%	9.1%	9.4%	10.0%	9.7%	9.6%
HOME HEALTH	361	441	547	726	1,160	1,510	1,879	2,209	2,439	2,773	3,148	3,543	3,937
% CHANGE	24.9%	22.2%	24.0%	32.7%	59.8%	30.2%	62.0%	17.6%	10.4%	13.7%	13.5%	12.5%	11.1%
HOSPICE						0	2	15	30	8	0	0	0
% CHANGE									100.0%	-73.3%	-100.0%		
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TOTAL HOSPITAL INSURANCE BENEFITS	17,411	19,891	23,790	28,907	34,343	38,102	41,461	47,864	48,314	52,254	57,931	64,096	70,696
				PIP ADJUSTMENT		38,992	41,581	46,922					
% CHANGE	16.8%	14.2%	19.6%	21.5%	18.8%	10.9%	20.7%	15.4%	0.9%	8.2%	10.9%	10.6%	10.3%
				PIP ADJUSTMENT		13.1%	21.0%	13.0%	3.0%				

Summary of HI Benefits Changes
(Dollars in Millions)

FY 1985 Estimate			$ 47,864
Population Increases			+1,007
Aged	+2.2%	$ 1,241	
Disabled	-1.2	-234	
Unit of Service per Capita Increase 1/			+171
Hospital, 2/ Aged and Disabled	+0.0%	$ 26	
Skilled Nursng Facility	+0.8%	5	
Home Health Agency	+5.6	140	
Reimbursement per Unit of Service Increases 1/			+2,949
Hospital	+3.8%	$ 2,764	
Skilled Nursing Facility	+6.4	44	
Home Health Agency	+5.8	141	
Cash Flow Changes			-1,714
Regulatory Actions			-2,096
Legislative Changes 3/			+133
FY 1986 Estimate			$ 48,314
Population Increases			+752
Aged	+2.2%	$ 906	
Disabled	-3.3	-154	
Unit of Service per Capita Increase 1/			+680
Hospital, Aged and Disabled	+1.3%	$ 563	
Skilled Nursing Facility	+0.4	3	
Home Health Agency	+4.6	114	
Reimbursement per Unit of Service Increases			+5,540
Hospital	+12.4%	$ 5,234	
Skilled Nursing Facility	+6.9	44	
Home Health Agency	+10.7	262	
Cash Flow Changes			-110
Regulatory Actions			-3,029
Legislative Changes			+107
FY 1987 Estimate			$ 52,254

1/ A unit of service is defined as an admission for hospital services, a day for skilled nursing facility services, and a visit for home health agency services.

2/ Changes in hospice amounts from year to year are included in hospital changes.

3/ Changes due to passage of the Social Security Disability Benefits Reform Act of 1984. Effects of moving to the Prospective Payment system and DEFRA are distributed in the base.

TABLE A2 - HI ENROLLEE DATA
(ENROLLEES IN THOUSANDS)

	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
HI ENROLLEES																	
o AGED																	
- Insured	2.7%	25,717	5.3%	26,282	2.2%	26,928	2.5%	27,588	2.5%	28,253	2.4%	28,882	2.2%	29,490	2.1%	30,095	2.1%
- Uninsured	-10.3%	477	-21.8%	416	-12.0%	359	-13.7%	306	-14.8%	263	-14.1%	225	-14.4%	193	-14.2%	163	-15.5%
- Fed Uninsured	0.0%	1	0.0%	3	0.0%	5	66.7%	8	60.0%	9	12.5%	10	11.1%	10	0.0%	9	-10.0%
- Self Pay	3.3%	21	5.0%	21	0.0%	22	4.8%	22	0.0%	23	4.5%	23	0.0%	24	4.3%	24	0.0%
SUBTOTAL	2.3%	26,216	4.6%	26,722	1.9%	27,314	2.2%	27,924	2.2%	28,548	2.2%	29,140	2.1%	29,717	2.0%	30,291	1.9%
o DISABLED																	
- Disabled	3.0%	2,870	-3.6%	2,845	-0.9%	2,925	2.8%	2,909	-0.5%	2,878	-1.1%	2,878	0.0%	2,891	0.5%	2,911	0.7%
- ESRD	9.2%	33	10.0%	34	3.0%	36	5.9%	37	2.8%	38	2.7%	38	0.0%	38	0.0%	38	0.0%
SUBTOTAL	3.0%	2,903	-3.5%	2,879	-0.8%	2,961	2.8%	2,946	-0.5%	2,916	-1.0%	2,916	0.0%	2,929	0.4%	2,949	0.7%
TOTAL ENROLLEES	2.3%	29,119	3.8%	29,601	1.7%	30,275	2.3%	30,970	2.0%	31,464	1.9%	32,056	1.9%	32,646	1.8%	33,240	1.8%
HI ENROLLEES RECEIVING REIMBURSEMENT																	
o AGED	3.8%	6,610	7.0%	6,850	3.6%	7,090	3.5%	7,340	3.5%	7,590	3.4%	7,820	3.0%	8,050	2.9%	8,280	2.9%
o DISABLED																	
- age 21 - 65		776		766	-1.3%	786	2.6%	786	0.0%	786	0.0%	786	0.0%	796	1.3%	806	1.3%
- under 21		4		4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%
SUBTOTAL	5.2%	780	4.0%	770	-1.3%	790	2.6%	790	0.0%	790	0.0%	790	0.0%	800	1.3%	810	1.3%
TOTAL RECEIVING REIMBURSEMENT	3.9%	7,390	6.6%	7,620	3.1%	7,880	3.4%	8,130	3.2%	8,380	3.1%	8,610	2.7%	8,850	2.8%	9,090	2.7%
TOTAL AS PERCENT OF ENROLLEES		25.4%		25.7%		26.0%		26.3%		26.6%		26.9%		27.1%		27.3%	

TABLE A3a - HI BENEFITS BY TYPE OF ENROLLEE

TOTAL BENEFITS PER ENROLLEE CATEGORY
(BENEFITS IN MILLIONS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED																	
- Insured	1.2%	32,929	11.7%	35,985	9.3%	41,693	15.9%	42,282	1.4%	46,011	8.8%	51,224	11.3%	56,869	11.0%	62,923	10.6%
- Uninsured	-5.2%	744	-2.1%	718	-3.5%	710	-1.1%	604	-14.9%	555	-8.1%	525	-5.4%	488	-7.0%	447	-8.4%
- Self Pay	1.3%	31	10.7%	30	-3.2%	38	26.7%	39	2.6%	42	7.7%	46	9.5%	52	13.0%	56	7.7%
SUBTOTAL	14.1%	33,704	11.3%	36,733	9.0%	42,441	15.5%	42,925	1.1%	46,608	8.6%	51,795	11.1%	57,409	10.8%	63,426	10.5%
o DISABLED																	
- Disabled	20.4%	4,145	28.2%	4,452	7.4%	5,118	15.0%	5,056	-1.2%	5,291	4.6%	5,746	8.6%	6,259	8.9%	6,809	8.8%
- ESRD	20.1%	253	36.0%	276	9.1%	305	10.5%	333	9.2%	355	6.6%	390	9.9%	428	9.7%	461	7.7%
SUBTOTAL	20.4%	4,398	28.7%	4,728	7.5%	5,423	14.7%	5,389	-0.6%	5,646	4.8%	6,136	8.7%	6,687	9.0%	7,270	8.7%
TOTAL REIMBURSEMENT	18.2%	38,102	31.9%	41,461	8.8%	47,864	15.4%	48,314	0.9%	52,254	8.2%	57,931	10.9%	64,096	10.6%	70,696	10.3%

BENEFITS PER ENROLLEE
(BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED																	
- Insured		1,280		1,369	6.9%	1,548	13.1%	1,533	-1.0%	1,629	6.3%	1,774	8.9%	1,928	8.7%	2,091	8.4%
- Uninsured		1,556		1,714	10.1%	1,951	13.8%	1,924	-1.4%	2,040	6.1%	2.234	9.5%	2,404	7.6%	2,599	8.1%
- Self Pay		1,476		1,429	-3.2%	1,727	20.9%	1,773	2.6%	1,826	3.0%	2,000	9.5%	2,167	8.3%	2,333	7.7%
SUBTOTAL	15.3%	1,286	26.4%	1,375	6.9%	1,554	13.0%	1,537	-1.1%	1,633	6.2%	1,777	8.9%	1,932	8.7%	2,094	8.4%
o DISABLED																	
- Disabled	17.0%	1,444	33.1%	1,565	8.4%	1,750	11.8%	1,738	-0.7%	1,838	5.8%	1,997	8.6%	2,165	8.4%	2,339	8.0%
- ESRD	10.1%	7,667	23.7%	8,118	5.9%	8,472	4.4%	9,000	6.2%	9,342	3.8%	10,263	9.9%	11,263	9.7%	12,132	7.7%
SUBTOTAL	16.9%	1,515	33.3%	1,642	8.4%	1,831	11.5%	1,829	-0.1%	1,936	5.8%	2,104	8.7%	2,283	8.5%	2,465	8.0%
TOTAL REIMBURSEMENT	15.5%	1,308	27.1%	1,401	7.0%	1,581	12.9%	1,565	-1.0%	1,661	6.1%	1,807	8.8%	1,963	8.6%	2,127	8.3%

BENEFITS PER ENROLLEE RECEIVING REIMBURSEMENT
(BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED	13.6%	5,099	23.7%	5,362	5.2%	5,986	11.6%	5,848	-2.3%	6,141	5.0%	6,623	7.9%	7,132	7.7%	7,660	7.4%
o DISABLED	14.5%	5,638	23.7%	6,140	8.9%	6,865	11.8%	6,822	-0.6%	7,147	4.8%	7,767	8.7%	8,359	7.6%	8,975	7.4%
TOTAL REIMBURSEMENT	13.7%	5,156	23.7%	5,441	5.5%	6,074	11.6%	5,943	-2.2%	6,236	4.9%	6,728	7.9%	7,242	7.6%	7,777	7.4%

TABLE A3b - HI BENEFITS BY TYPE OF ENROLLEE ADJUSTED FOR PIP DELAY IMPACT

TOTAL BENEFITS PER ENROLLEE CATEGORY
(BENEFITS IN MILLIONS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED																	
- Insured		33,655		36,054	7.1%	40,872	13.4%	42,282	3.4%	46,011	8.8%	51,224	11.3%	56,869	11.0%	62,923	10.6%
- Uninsured		760		719	-5.4%	696	-3.2%	604	-13.2%	555	-8.1%	525	-5.4%	488	-7.0%	447	-8.4%
- Self Pay		32		30	-5.1%	37	23.9%	39	4.7%	42	7.7%	46	9.5%	52	13.0%	56	7.7%
SUBTOTAL	17.9%	34,447	35.2%	36,804	6.8%	41,606	13.0%	42,925	3.2%	46,608	8.6%	51,795	11.1%	57,409	10.8%	63,426	10.5%
o DISABLED																	
- Disabled	20.4%	4,236	31.1%	4,461	5.3%	5,017	12.5%	5,056	0.8%	5,291	4.6%	5,746	8.6%	6,259	8.9%	6,809	8.8%
- ESRD	20.1%	259	39.0%	277	6.9%	299	8.1%	333	11.4%	355	6.6%	390	9.9%	428	9.7%	461	7.7%
SUBTOTAL	20.4%	4,495	31.5%	4,737	5.4%	5,316	12.2%	5,389	1.4%	5,646	4.8%	6,136	8.7%	6,687	9.0%	7,270	8.7%
TOTAL REIMBURSEMENT	18.2%	38,942	34.8%	41,541	6.7%	46,922	13.0%	48,314	3.0%	52,254	8.2%	57,931	10.9%	64,096	10.6%	70,696	10.3%

BENEFITS PER ENROLLEE
(BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED																	
- Insured		1,309		1,372	4.8%	1,518	10.6%	1,533	1.0%	1,629	6.3%	1,774	8.9%	1,928	8.7%	2,091	8.4%
- Uninsured		1,591		1,717	7.9%	1,912	11.4%	1,924	0.6%	2,040	6.1%	2,234	9.5%	2,404	7.6%	2,599	8.1%
- Self Pay		1,509		1,431	-5.1%	1,693	18.3%	1,773	4.7%	1,826	3.0%	2,000	9.5%	2,167	8.3%	2,333	7.7%
SUBTOTAL	15.3%	1,314	29.2%	1,377	4.8%	1,523	10.6%	1,537	0.9%	1,633	6.2%	1,777	8.9%	1,932	8.7%	2,094	8.4%
o DISABLED																	
- Disabled	17.0%	1,476	36.0%	1,568	6.2%	1,715	9.4%	1,738	1.3%	1,838	5.0%	1,997	8.6%	2,165	8.4%	2,339	8.0%
- ESRD	10.1%	7,836	26.4%	8,133	3.8%	8,305	2.1%	9,000	8.4%	9,342	3.8%	10,263	9.9%	11,263	9.7%	12,132	7.7%
SUBTOTAL	16.9%	1,548	36.3%	1,645	6.3%	1,795	9.1%	1,829	1.9%	1,936	5.8%	2,104	8.7%	2,203	8.5%	2,465	8.0%
TOTAL REIMBURSEMENT	15.5%	1,337	29.9%	1,403	4.9%	1,550	10.4%	1,565	1.0%	1,661	6.1%	1,807	8.8%	1,963	8.6%	2,127	8.3%

BENEFITS PER ENROLLEE RECEIVING REIMBURSEMENT
(BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED	13.6%	5,211	26.4%	5,373	3.1%	5,868	9.2%	5,848	-0.3%	6,141	5.0%	6,623	7.9%	7,132	7.7%	7,660	7.4%
o DISABLED	14.5%	5,763	26.5%	6,152	6.8%	6,729	9.4%	6,822	1.4%	7,147	4.8%	7,767	8.7%	8,359	7.6%	8,975	7.4%
TOTAL REIMBURSEMENT	13.7%	5,270	26.4%	5,452	3.5%	5,955	9.2%	5,943	-0.2%	6,236	4.9%	6,728	7.9%	7,242	7.6%	7,777	7.4%

TABLE A4a - HI BENEFITS BY TYPE OF SERVICE
(BENEFITS IN MILLIONS)

	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o INPATIENT HOSPITAL																	
- Aged	17.8%	31,815	10.6%	34,468	8.3%	39,800	15.5%	40,001	0.5%	43,326	8.3%	48,098	11.0%	53,264	10.7%	58,826	10.4%
- Disabled	20.2%	4,262	7.5%	4,567	7.2%	5,237	14.7%	5,186	-1.0%	5,427	4.6%	5,893	8.6%	6,420	8.9%	6,981	8.7%
SUBTOTAL	18.1%	36,077	10.2%	39,035	8.2%	45,037	15.4%	45,187	0.3%	48,753	7.9%	53,991	10.7%	59,684	10.5%	65,807	10.3%
o SKILLED NURSING FACILITIES																	
- Aged	5.4%	498	13.7%	526	5.6%	583	10.0%	636	9.1%	697	9.6%	767	10.0%	843	9.9%	924	9.6%
- Disabled	4.3%	17	6.3%	19	11.8%	20	5.3%	22	10.0%	23	4.5%	25	8.7%	26	4.0%	28	7.7%
SUBTOTAL	5.3%	515	13.4%	545	5.0%	603	10.6%	658	9.1%	720	9.4%	792	10.0%	869	9.7%	952	9.6%
o HOME HEALTH																	
- Aged	27.7%	1,391	30.5%	1,737	24.9%	2,044	17.7%	2,260	10.6%	2,577	14.0%	2,930	13.7%	3,302	12.7%	3,676	11.3%
- Disabled	30.5%	119	26.6%	142	19.3%	165	16.2%	179	8.5%	196	9.5%	218	11.2%	241	10.6%	261	8.3%
SUBTOTAL	27.9%	1,510	30.2%	1,879	24.4%	2,209	17.6%	2,439	10.4%	2,773	13.7%	3,148	13.5%	3,543	12.5%	3,937	11.1%
o HOSPICE																	
- Aged		0	0	2	100.0%	14	600.0%	28	100.0%	8	-71.4%	0	-100.0%	0	0.0%	0	0.0%
- Disabled		0	0	0	0.0%	1	100.0%	2	100.0%	0	-100.0%	0	0.0%	0	0.0%	0	0.0%
SUBTOTAL	0.0%	0	0	2	100.0%	15	650.0%	30	100.0%	8	-73.3%	0	-100.0%	0	0.0%	0	0.0%
TOTAL REIMBURSEMENT	10.2%	38,102	10.9%	41,461	8.8%	47,864	15.4%	48,314	0.9%	52,254	8.2%	57,931	10.9%	64,096	10.6%	70,696	10.3%

TABLE A4b - HI BENEFITS BY TYPE OF SERVICE ADJUSTED FOR PIP DELAY IMPACT
(BENEFITS IN MILLIONS)

	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o INPATIENT HOSPITAL																	
- Aged	17.8%	32,556	33.4%	34,539	6.1%	38,968	12.9%	40,001	2.7%	43,326	8.3%	48,098	11.0%	53,264	10.7%	58,826	10.4%
- Disabled	20.2%	4,361	30.3%	4,576	4.9%	5,127	12.0%	5,186	1.1%	5,427	4.6%	5,893	8.6%	6,420	8.9%	6,981	8.7%
SUBTOTAL	18.1%	36,917	33.1%	39,115	6.0%	44,095	12.7%	45,187	2.5%	48,753	7.9%	53,991	10.7%	59,684	10.5%	65,807	10.3%
o SKILLED NURSING FACILITIES																	
- Aged	5.4%	498	22.1%	526	5.6%	583	10.8%	636	9.1%	697	9.6%	767	10.0%	843	9.9%	924	9.6%
- Disabled	4.3%	17	6.3%	19	11.8%	20	5.3%	22	10.0%	23	4.5%	25	8.7%	26	4.0%	28	7.7%
SUBTOTAL	5.3%	515	21.5%	545	5.8%	603	10.6%	658	9.1%	720	9.4%	792	10.0%	869	9.7%	952	9.6%
o HOME HEALTH																	
- Aged	32.5%	1,391	107.6%	1,737	24.9%	2,044	17.7%	2,260	10.6%	2,577	14.0%	2,930	13.7%	3,302	12.7%	3,676	11.3%
- Disabled	35.8%	119	112.5%	142	19.3%	165	16.2%	179	8.5%	196	9.5%	218	11.2%	241	10.6%	261	8.3%
SUBTOTAL	32.7%	1,510	108.0%	1,879	24.4%	2,209	17.6%	2,439	10.4%	2,773	13.7%	3,148	13.5%	3,543	12.5%	3,937	11.1%
o HOSPICE																	
- Aged	0.0%	0	0.0%	2	100.0%	14	600.0%	28	100.0%	8	-71.4%	0	-100.0%	0	0.0%	0	0.0%
- Disabled	0.0%	0	0.0%	0	0.0%	1	100.0%	2	100.0%	0	-100.0%	0	0.0%	0	0.0%	0	0.0%
SUBTOTAL	0.0%	0	0.0%	2	100.0%	15	100.0%	30	100.0%	8	-73.3%	0	-100.0%	0	0.0%	0	0.0%
TOTAL REIMBURSEMENT	18.2%	38,942	34.0%	41,541	6.7%	46,922	13.0%	48,314	3.0%	52,254	8.2%	57,931	10.9%	64,096	10.6%	70,696	10.3%

TABLE A5 - ASSUMPTIONS FOR HOSPITAL INSURANCE PROJECTIONS

	FY 1984	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
INPATIENT HOSPITAL													
o ADMISSIONS (in thousands)													
- Previous Estimate	11,713	11,857	1.2%	12,089	2.0%	12,478	3.2%	12,917	3.5%	13,353	3.4%	13,827	3.5%
- Current Estimate	11,718	11,857	1.2%	12,089	2.0%	12,478	3.2%	12,917	3.5%	13,353	3.4%	13,827	3.5%
CHANGE	5	0		0		0		0		0		0	
o REIMBURSEMENT/ADMISSION													
- Previous Estimate	3,353	3,669	9.4%	3,715	1.3%	3,918	5.5%	4,190	6.9%	4,480	6.9%	4,775	6.6%
- Current Estimate	3,351	3,669	9.5%	3,709	1.1%	3,913	5.5%	4,184	6.9%	4,474	6.9%	4,768	6.6%
CHANGE	(2)	0		(6)		(5)		(6)		(6)		(7)	
SNF DAYS/ENROLLEE													
- Previous Estimate	0.321	0.328	2.2%	0.331	0.9%	0.333	0.6%	0.335	0.6%	0.337	0.6%	0.339	0.6%
- Current Estimate	0.321	0.328	2.2%	0.331	0.9%	0.333	0.6%	0.335	0.6%	0.337	0.6%	0.339	0.6%
CHANGE	0.000	0.000		0.000		0.000		0.000		0.000		0.000	
o REIMBURSEMENT/DAY													
- Previous Estimate	$59	$62	5.1%	$66	6.5%	$70	6.1%	$75	7.1%	$81	8.0%	$86	6.2%
- Current Estimate	$59	$62	5.1%	$66	6.5%	$71	7.6%	$76	7.0%	$81	6.6%	$87	7.4%
CHANGE	0.000	0.000		0.000		1.000		1.000		0.000		1.000	
HHA VISITS/ENROLLEE													
- Previous Estimate	1.352	1.436	6.2%	1.462	1.8%	1.469	0.5%	1.477	0.5%	1.485	0.5%	1.494	0.6%
- Current Estimate	1.352	1.436	6.2%	1.517	5.6%	1.589	4.7%	1.649	3.0%	1.695	2.0%	1.727	1.9%
CHANGE	0.000	0.000		0.055		0.120		0.172		0.210		0.233	
o REIMBURSEMENT/VISIT													
- Previous Estimate	$50	$53	6.0%	$54	1.9%	$58	7.4%	$62	6.9%	$67	8.1%	$71	6.0%
- Current Estimate	$50	$53	6.0%	$54	1.9%	$58	7.4%	$62	6.9%	$67	8.1%	$71	6.0%
CHANGE	0.000	0.000		0.000		0.000		0.000		0.000		0.000	

	1984	1985	1986	1987	1988	1989	1990
HOSPITAL MARKET BASKET							
- Previous Estimate	5.2%	5.2%	6.3%	6.6%	6.9%	7.1%	6.4%
- Current Estimate	5.2%	4.9%	6.3%	6.6%	6.9%	7.1%	6.5%
CHANGE	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	-0.1%

Table A6 - HI INPATIENT DEDUCTIBLE AND BUY-IN PREMIUM

Calendar Year	HI Inpatient Deductible
1966-68	$ 40
1969	44
1970	52
1971	60
1972	68
1973	72
1974	84
1975	92
1976	104
1977	124
1978	144
1979	160
1980	180
1981	204
1982	260
1983	304
1984	356
1985	400
1986	476
1987	524
1988	544
1989	580
1990	624

Old Fiscal Year	HI Premium
1974	$ 33
1975	36
1976	40
1977	45
1978	54
1979	63
1980	69
1981	78
1982	89
1983	113
July-Dec 83	113
Calendar Year	
1984	155
1985	174
1986	207
1987	228
1988	236
1989	252
1990	271

Supplementary Medical Insurance

Benefits under the Supplementary Medical Insurance program are estimated to amount to $28.1 billion by FY 1987. This is $2.7 billion or 10.5 perent higher than FY 1986. This increase returns to the levels experienced in FY 1984 and FY 1985. The increase remains the result of higher inflation, enrollement and utilization.

Within Part B the increase is distributed among the services as follows:

- physician services are projected to be $19.5 billion, an increase of 8.5 percent over FY 1986;
- outpatient services will be $6.2 billion, an increase of 15.8 percent;
- payments for radiology and pathology will be $747 million, 9.4 percent higher than FY 1986;
- group practice will be $989 million, up 23.3 percent;
- independent lab services will total $648 million, an increase of 7.6 percent;
- and home health services will be $27 million up 12.5 percent from the previous year.

The total increase for Part B services above can be attributed to the following factors:

- 16.6 percent of the increase is the direct result of increases in physician fees which are expected to go up by about 4.8 percent.
- Another 25.5 percent of the increase is due to changes in utilization, the mix of services and other factors related to physician services.
- Increases in outpatient benefits, both in terms of higher reimbursement and utilization, account for 25.8 percent of the increase.
- Other benefit increases account for 11.5 percent of the change. Of this total, ESRD increases account for 20 percent.
- The "static deductible", will account for 1.0 percent of the total increase in outlays. Although the deductible increased in 1982 to $75, there is no provision under current law for further increases. As a result, the percent of program cost which the program reimburses will increase.
- Finally, growth in enrollment is responsible for 18.8 percent of the increase. The number of enrollees is projected to increase from 30.6 million to 31.2 million or by 2.1 percent. The percentage of enrollees receiving reimbursement is estimated to increase from 73.3 percent to 74.0 percent. As with Part A, the increase in enrollees is a net of an increase in the aged category and a decrease in disabled.

Benefits per enrollee receiving reimbursement will increase by 7.4 percent for aged and 7.6 percent for disabled, while the medical CPI is expected to increase by 5.9 percent. The average amount of benefits received per enrollee will be $846 for aged, $1,277 for disabled non-ESRD and $18,265 for ESRD. For enrollees receiving reimbursement, benefits will average $1,143 for aged and $2,032 for disabled.

Based on Spring Review economic assumptions, the current law projection shows the rate of program increase increasing from 10.5 percent in FY 1987 to 12.8 percent by FY 1990. (Actuarial projections for FY 1990 will be developed for Fall Directors Review when economic assumption are received.) By FY 1990, benefits will have reached $40.4 billion, 44 percent higher than FY 1987. The outyear increases will still be driven by increases in physician fees and utilization. Enrollment is expected to grow at a marginally lower rates from FY 1989. The percent of enrollees receiving reimbursement will be 75.6 percent as opposed to 74.0 percent in FY 1987.

Passage of the Social Security Disability Reform Act of 1984 had the effect of increasing the disabled population. Number of enrollees increased because the law kept more enrollees enrolled by encouraging appeals of termination notices and requiring a demonstration that the medical condition(s) or technology has improved to allow a beneficiary to return to work before disenrolling them.

The Part B trust fund is different from Part A in that it is financed on a year-to-year basis through the annual promulgation of the adequate rate. The fund's balance by law is required to be sufficient to finance all current liabilities plus carry a contingency to cover estimating error. Financing is planned so that over FY 1986-1989 period, the balance will decline from approximately 34 percent to about 17 percent of the following year's outlays.

TABLE B1 - HISTORICAL MEDICARE PART B OUTLAYS BY SERVICE
(DOLLARS IN MILLIONS)

	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971	FY 1972	FY 1973	FY 1974	FY 1975	FY 1976	TQ 1976	FY 1977	FY 1978
PHYSICIAN	627	1,292	1,462	1,581	1,695	1,868	1,971	2,265	2,873	3,439	897	4.286	4,954
% CHANGE		106.1%	13.2%	8.1%	7.2%	10.2%	5.5%	14.9%	26.8%	19.7%	N/A	N/A	15.6%
RADIOLOGY AND PATHOLOGY	2	12	54	233	136	128	147	161	192	251	71	313	373
% CHANGE		500.0%	350.0%	331.5%	-41.6%	-5.9%	14.8%	9.5%	19.3%	30.7%	N/A	N/A	19.2%
TOTAL PHYSICIAN	629	1,304	1,516	1,814	1,831	1,996	2,118	2,426	3,065	3,690	968	4,599	5,327
% CHANGE		107.3%	16.3%	19.7%	0.9%	9.0%	6.1%	14.5%	26.3%	20.4%	N/A	N/A	15.8%
OUTPATIENT	10	32	67	93	137	174	175	319	509	717	231	953	1,184
% CHANGE		220.0%	109.4%	38.8%	47.3%	27.0%	0.6%	82.3%	59.6%	40.9%	N/A	N/A	24.2%
GROUP PRACTICE	14	22	26	27	26	32	36	49	62	99	23	104	90
% CHANGE		57.1%	18.2%	3.8%	-3.7%	23.1%	12.5%	36.1%	26.5%	59.7%	N/A	N/A	-13.5%
INDEPENDENT LAB	3	8	7	10	11	16	19	21	34	44	13	59	69
% CHANGE		166.7%	-12.5%	42.9%	10.0%	45.5%	18.8%	10.5%	61.9%	29.4%	N/A	N/A	16.9%
HOME HEALTH	8	24	29	35	30	37	43	59	95	122	38	152	182
% CHANGE		200.0%	20.8%	20.7%	-14.3%	23.3%	16.2%	37.2%	61.0%	28.4%	N/A	N/A	19.7%
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TOTAL BENEFITS	664	1,390	1,645	1,979	2,035	2,255	2,391	2,874	3,765	4,672	1,269	5,867	6,852
% CHANGE		109.3%	18.3%	20.3%	2.8%	10.8%	6.0%	20.2%	31.0%	24.1%	20.8%	20.2%	16.8%

	FY 1979	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY1987	FY 1988	FY 1989	FY 1990
PHYSICIAN	5,948	7,283	8,859	10,649	12,915	14,334	15,300	18,015	19,544	21,685	24,173	26,982
% CHANGE	20.1%	22.4%	21.6%	20.2%	21.3%	11.0%	6.7%	17.7%	8.5%	11.0%	11.5%	11.6%
RADIOLOGY AND PATHOLOGY	449	531	654	742	611	604	583	683	747	836	937	1,050
% CHANGE	20.4%	18.3%	23.2%	13.5%	-17.7%	-1.1%	-3.5%	17.2%	9.4%	11.9%	12.1%	12.1%
TOTAL PHYSICIAN	6,397	7,814	9,513	11,390	13,526	14,938	15,883	18,698	20,291	22,521	25,110	28,032
% CHANGE	20.1%	22.2%	21.7%	19.7%	18.8%	10.4%	6.3%	17.7%	8.5%	11.0%	11.5%	11.6%
OUTPATIENT	1,445	1,809	2,215	2,916	3,361	3,739	4,388	5,338	6,184	7,280	8,429	9,759
% CHANGE	22.0%	25.2%	22.4%	31.6%	15.3%	11.2%	17.4%	21.6%	15.8%	17.7%	15.8%	15.8%
GROUP PRACTICE	122	190	243	308	394	506	653	802	989	1,207	1,434	1,699
% CHANGE	35.6%	55.7%	27.9%	26.7%	27.9%	28.4%	29.1%	22.8%	23.3%	22.0%	18.8%	18.5%
INDEPENDENT LAB	89	106	141	175	190	273	487	602	648	716	790	868
% CHANGE	29.0%	19.1%	33.0%	24.1%	8.6%	43.7%	78.4%	23.6%	7.6%	10.5%	10.3%	9.9%
HOME HEALTH	206	225	233	17	16	19	25	24	27	29	33	37
% CHANGE	13.2%	9.2%	3.6%	-92.7%	-5.9%	18.8%	31.6%	-4.0%	12.5%	7.4%	13.8%	12.1%
	------	------	------	------	------	------	------	------	------	------	------	------
TOTAL BENEFITS	8,259	10,144	12,345	14,806	17,487	19,475	21,436	25,464	28,139	31,753	35,796	40,395
% CHANGE	20.5%	22.9%	21.7%	19.9%	18.1%	11.4%	10.1%	18.8%	10.5%	12.8%	12.7%	12.8%

TABLE B5—Summary of SMI Benefits Changes
FY 1986 Budget (2): Spring Review
($ Millions)

FY 1985 Estimate			**$21,439**
Physician Fee Increases			1,825
Aged	5.4%	$1653	
Disabled (Non-ESRD)	5.4	172	
Physician Utilization Increases			564
Aged	3.5%	$ 484	
Disabled (Non-ESRD)	5.6	80	
Outpatient Benefit Increases			825
Aged	16.0%	$ 706	
Disabled (Non-ESRD)	17.8	119	
Other Benefit Increases			324
Aged	13.1%	$ 295	
Disabled (Non-ESRD)	14.3	29	
Static Deductible 1/			34
Aged		$ 31	
Disabled (Non-ESRD)		3	
Population Increase			456
Aged	2.4%	$ 446	
Disabled (Non-ESRD)	-2.2	-45	
ESRD Increases			72
Medical Cost Increase	4.6%	55	
Population Increase	1.4	17	
Regulatory Items 2/			-72
Legislative Changes 3/			+55
1986 Estimate			**$25,464**

1/ Because the SMI deductible does not increase each year, even though total covered medical cost [illegible], the percentage of covered cost which the program reimburses is higher each year.

2/ Regulatory Items:

	FY 1986	FY 1987
Freeze DME, Other	-50	-106
Waiver of Liability	-22	-35
Total Regulatory Items	-72	-141

3/ Changes due to the passage of the Social Security Disability Benefits Reform Act of 1984. The effects of changes to the Prospective Payment system and the impact of [illegible] are attributed to the base.

TABLE B5—Summary of SMI Benefits Changes
FY 1986 Budget (2): Spring Review
($ Millions)

FY 1986 Estimate			**$25,464**
Physician Fee Increases			456
Aged	4.8%	$ 411	
Disabled (Non-ESRD)	4.9%	45	
Physician Utilization Increases			700
Aged	3.7%	$ 606	
Disabled (Non-ESRD)	5.6	94	
Outpatient Benefit Increases			710
Aged	15.5%	$ 616	
Disabled (Non-ESRD)	15.4	94	
Other Benefit Increases			251
Aged	13.8	$ 230	
Disabled (Non-ESRD)	16.0	21	
Static Deductible[1/]			28
Aged		$ 26	
Disabled (Non-ESRD)		2	
Population Increase			462
Aged	2.4%	$ 528	
Disabled (Non-ESRD)	-.4%	-66	
ESRD Increases			64
Medical Cost Increase	2.2%	28	
Population Increase	2.9	36	
Regulatory Items[2/]			-73
Legislative Changes[3/]			+55
1987 Estimate			**$28,139**

[1/] Because the SMI deductible does not increase each year, even through total covered medical cost do, the percentage of covered cost which the program reimburse is higher each year.

[2/] Regulatory Items:

	FY 1986	FY 1987
Freeze DME, Other	-50	-100
Waiver of Liability	-22	-23
Total Regulatory Item:	-72	-123

[3/] Changes due to the passage of the Social Security Disability Benefits Reform Act of 1984. The effects of moving to the Prospective Payment System and the impact of DEFRA are distributed in the base.

TABLE B2 - SMI ENROLLEE DATA
(ENROLLEES IN THOUSANDS)

	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
SMI ENROLLEES																	
o AGED	2.3%	26,008	2.0%	26,570	2.2%	27,161	2.2%	27,865	2.6%	28,513	2.3%	29,124	2.1%	29,726	2.1%	30,314	2.0%
o DISABLED																	
- Disabled	3.3%	2,643	-1.9%	2,631	-0.5%	2,648	0.6%	2,664	0.6%	2,651	-0.5%	2,653	0.1%	2,665	0.5%	2,685	0.8%
- ESRD	9.2%	33	6.5%	30	-9.1%	32	6.7%	33	3.1%	34	3.0%	35	2.9%	36	2.9%	37	2.8%
SUBTOTAL	3.4%	2,676	-1.8%	2,661	-0.6%	2,680	0.7%	2,697	0.6%	2,685	-0.4%	2,688	0.1%	2,701	0.5%	2,722	0.8%
TOTAL ENROLLEES	2.4%	28,684	1.7%	29,231	1.9%	29,841	2.1%	30,562	2.4%	31,198	2.1%	31,812	2.0%	32,427	1.9%	33,036	1.9%
SMI ENROLLEES RECEIVING REIMBURSEMENT																	
o AGED	5.5%	17,815	3.1%	19,051	6.9%	19,699	3.4%	20,446	3.8%	21,114	3.3%	21,734	2.9%	22,332	2.8%	22,925	2.7%
o DISABLED																	
- age 21 - 65		1,756	0.9%	1,883	7.2%	1,923	2.1%	1,958	1.8%	1,968	0.5%	1,988	1.0%	2,012	1.2%	2,042	1.5%
- under 21		3	0.0%	2	-33.3%	3	50.0%	3	0.0%	3	0.0%	3	0.0%	3	0.0%	3	0.0%
SUBTOTAL	7.8%	1,759	0.9%	1,885	7.2%	1,926	2.2%	1,961	1.8%	1,971	0.5%	1,991	1.0%	2,015	1.2%	2,045	1.5%
TOTAL RECEIVING REIMBURSEMENT	5.7%	19,574	2.9%	20,936	7.0%	21,625	3.3%	22,407	3.6%	23,085	3.0%	23,725	2.8%	24,347	2.6%	24,970	2.6%
TOTAL AS PERCENT OF ENROLLEES		68.2%		71.6%		72.5%		73.3%		74.0%		74.6%		75.1%		75.6%	

TABLE B3 - SMI BENEFITS BY TYPE OF ENROLLEE

TOTAL BENEFITS PER ENROLLEE CATEGORY
(BENEFITS IN MILLIONS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED	19.9%	14,726	18.7%	16,563	12.5%	18,208	9.9%	21,761	19.5%	24,133	10.9%	27,336	13.3%	30,914	13.1%	34,973	13.1%
o DISABLED																	
- Disabled	24.5%	2,097	11.5%	2,393	14.1%	2,666	11.4%	3,112	16.7%	3,385	8.8%	3,766	11.3%	4,198	11.5%	4,703	12.0%
- ESRD	18.7%	664	27.2%	519	-21.8%	562	8.3%	591	5.2%	621	5.1%	651	4.8%	684	5.1%	719	5.1%
SUBTOTAL	23.1%	2,761	14.9%	2,912	5.5%	3,228	10.9%	3,703	14.7%	4,006	8.2%	4,417	10.3%	4,882	10.5%	5,422	11.1%
TOTAL REIMBURSEMENT	20.4%	17,487	18.1%	19,475	11.4%	21,436	10.1%	25,464	18.8%	28,139	10.5%	31,753	12.8%	35,796	12.7%	40,395	12.8%

BENEFITS PER ENROLLEE
(BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED	17.2%	566	16.4%	623	10.1%	670	7.5%	781	16.5%	846	8.4%	939	10.9%	1,040	10.8%	1,154	10.9%
o DISABLED																	
- Disabled	20.5%	793	13.7%	910	14.6%	1,007	10.7%	1,168	16.0%	1,277	9.3%	1,420	11.2%	1,575	11.0%	1,732	11.2%
- ESRD	8.0%	20,121	19.5%	17,300	-14.0%	17,563	1.5%	17,909	2.0%	18,265	2.0%	18,600	1.8%	19,000	2.2%	19,432	2.3%
SUBTOTAL	19.1%	1,032	17.1%	1,094	6.1%	1,204	10.1%	1,373	14.0%	1,492	8.7%	1,643	10.1%	1,807	10.0%	1,992	10.2%
TOTAL REIMBURSEMENT	17.5%	610	16.2%	666	9.3%	718	7.8%	833	16.0%	902	8.3%	998	10.7%	1,104	10.6%	1,223	10.8%

BENEFITS PER ENROLLEE RECEIVING REIMBURSEMENT
(BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89
o AGED	13.7%	827	15.2%	869	5.2%	924	6.3%	1,064	15.1%	1,143	7.4%	1,258	10.0%	1,384	10.1%	1,526	10.2%
o DISABLED	14.4%	1,570	13.9%	1,545	-1.6%	1,676	8.5%	1,888	12.7%	2,032	7.6%	2,218	9.2%	2,423	9.2%	2,651	9.4%
TOTAL REIMBURSEMENT	14.0%	893	14.8%	930	4.1%	991	6.6%	1,136	14.6%	1,219	7.3%	1,338	9.8%	1,470	9.9%	1,618	10.0%

TABLE B4 - SMI BENEFITS BY TYPE OF SERVICE
(BENEFITS IN MILLIONS)

	AVE % CHANGE 77-82	FY 1983	% CHANGE FROM '82	FY 1984	% CHANGE FROM '83	FY 1985	% CHANGE FROM '84	FY 1986	% CHANGE FROM '85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY1990	% CHANGE FROM '89
o PHYSICIAN																	
- Aged	19.4%	11,501	22.9%	12,671	10.2%	13,498	6.5%	15,930	18.0%	17,309	8.7%	19,234	11.1%	21,465	11.6%	23,974	11.7%
- Disabled	24.8%	1,414	9.9%	1,663	17.6%	1,802	0.4%	2,085	15.7%	2,235	7.2%	2,451	9.7%	2,708	10.5%	3,008	11.1%
SUBTOTAL	20.0%	12,915	21.3%	14,334	11.0%	15,300	6.7%	18,015	17.7%	19,544	8.5%	21,685	11.0%	24,173	11.5%	26,982	11.6%
o RADIOLOGY & PATHOLOGY																	
- Aged	18.3%	552	-15.3%	548	-0.7%	528	-3.6%	620	17.4%	680	9.7%	762	12.1%	856	12.3%	960	12.1%
- Disabled	23.9%	59	-34.4%	56	-5.1%	55	-1.8%	63	14.5%	67	6.3%	74	10.4%	81	9.5%	90	11.1%
SUBTOTAL	18.9%	611	-17.7%	604	-1.1%	583	-3.5%	683	17.2%	747	9.4%	836	11.9%	937	12.1%	1,050	12.1%
TOTAL PHYSICIAN																	
- Aged	19.3%	12,053	20.4%	13,219	9.7%	14,026	6.1%	16,550	10.0%	17,989	8.7%	19,996	11.2%	22,321	11.6%	24,934	11.7%
- Disabled	24.7%	1,473	7.0%	1,719	16.7%	1,857	8.0%	2,148	15.7%	2,302	7.2%	2,525	9.7%	2,789	10.5%	3,098	11.1%
TOTAL	19.9%	13,526	18.8%	14,938	10.4%	15,883	6.3%	18,698	17.7%	20,291	8.5%	22,521	11.0%	25,110	11.5%	28,032	11.6%
o OUTPATIENT																	
- Aged	27.1%	2,120	8.8%	2,614	23.3%	3,119	19.3%	3,908	25.3%	4,621	18.2%	5,553	20.2%	6,528	17.6%	7,660	17.3%
- Disabled	21.6%	1,241	28.2%	1,125	-9.3%	1,269	12.8%	1,430	12.7%	1,563	9.3%	1,727	10.5%	1,901	10.1%	2,099	10.4%
SUBTOTAL	25.1%	3,361	15.3%	3,739	11.2%	4,388	17.4%	5,338	21.6%	6,184	15.8%	7,280	17.7%	8,429	15.8%	9,759	15.8%
o GROUP PRACTICE																	
- Aged	25.9%	372	37.3%	481	29.3%	618	28.5%	757	22.5%	931	23.0%	1,131	21.5%	1,338	16.3%	1,578	17.9%
- Disabled	31.3%	22	-40.5%	25	13.6%	35	40.0%	45	28.6%	58	28.9%	76	31.0%	96	26.3%	121	26.0%
SUBTOTAL	26.5%	394	27.9%	506	28.4%	653	29.1%	802	22.8%	989	23.3%	1,207	22.0%	1,434	18.0%	1,699	18.5%
o INDEPENDENT LAB																	
- Aged	24.2%	165	5.8%	230	39.4%	420	82.6%	522	24.3%	565	8.2%	627	11.0%	694	10.7%	764	10.1%
- Disabled	26.1%	25	31.6%	43	72.0%	67	55.8%	80	19.4%	83	3.8%	89	7.2%	96	7.9%	104	8.3%
SUBTOTAL	24.4%	190	8.6%	273	43.7%	487	78.4%	602	23.6%	648	7.6%	716	10.5%	790	10.3%	868	9.9%
o HOME HEALTH																	
- Aged	-9.4%	16	0.0%	19	18.8%	25	31.6%	24	-4.0%	27	12.5%	29	7.4%	33	13.0%	37	12.1%
- Disabled	-9.6%	0	-100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
SUBTOTAL	-9.4%	16	-5.9%	19	18.8%	25	31.6%	24	-4.0%	27	12.5%	29	7.4%	33	13.0%	37	12.1%
TOTAL REIMBURSEMENT	20.4%	17,407	18.1%	19,475	11.4%	21,436	10.1%	25,464	10.8%	28,139	10.5%	31,753	12.8%	35,796	12.7%	40,395	12.8%

TABLE B5 - ASSUMPTIONS FOR SUPPLEMENTARY MEDICAL INSURANCE PROJECTION

	1983	1984	1985	1986	1987	1988	1989	1990
ECONOMIC INDEX								
- Previous Estimate	8.88%	5.85%	0.00%	4.00%	3.53%	4.61%	4.81%	4.78%
- Current Estimate	8.88%	5.85%	0.00%	4.00%	3.14%	4.55%	4.75%	4.78%
CHANGE	0.00%	0.00%	0.00%	0.00%	-0.39%	-0.06%	-0.06%	0.00%

	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
PHYSICIAN FEES (AGED)								
- Previous Estimate	8.1%	5.4%	1.9%	5.5%	5.0%	5.0%	5.1%	5.1%
- Current Estimate	8.1%	5.5%	1.9%	5.4%	4.8%	4.8%	5.1%	5.1%
CHANGE	0.0%	0.1%	0.0%	-0.1%	-0.2%	-0.2%	0.0%	0.0%
PHYSICIAN FEES (DISABLED)								
- Previous Estimate	8.2%	5.4%	1.9%	5.4%	5.1%	4.9%	5.1%	5.0%
- Current Estimate	8.2%	5.5%	2.0%	5.4%	4.9%	4.8%	5.1%	5.0%
CHANGE	0.0%	0.1%	0.1%	0.0%	-0.2%	-0.1%	0.0%	0.0%
PHYSICIAN RESIDUAL (AGED)								
- Previous Estimate	11.8%	3.4%	4.2%	3.5%	3.7%	3.6%	3.7%	3.9%
- Current Estimate	11.8%	3.1%	3.5%	3.5%	3.7%	3.6%	3.7%	3.9%
CHANGE	0.0%	-0.3%	-0.7%	0.0%	0.0%	0.0%	0.0%	0.0%
PHYSICIAN RESIDUAL (DISABLED)								
- Previous Estimate	11.3%	4.5%	5.9%	5.6%	5.6%	5.6%	5.7%	6.0%
- Current Estimate	11.3%	4.2%	5.1%	5.6%	5.6%	5.6%	5.7%	6.0%
CHANGE	0.0%	-0.3%	-0.8%	0.0%	0.0%	0.0%	0.0%	0.0%
RADIOLOGY & PATHOLOGY								
- AGED	-1.5%	-2.4%	3.3%	8.8%	9.5%	9.3%	9.4%	9.6%
- DISABLED	1.0%	-2.9%	3.7%	8.8%	10.2%	9.9%	9.2%	9.8%
OUTPATIENT								
- AGED	16.4%	20.5%	18.2%	16.0%	15.5%	18.3%	14.4%	14.6%
- DISABLED	18.3%	16.7%	21.3%	17.8%	15.4%	18.2%	14.3%	14.5%
HOME HEALTH								
- AGED	10.0%	18.0%	10.2%	9.2%	11.3%	7.6%	10.6%	9.6%
GROUP PRACTICE								
- AGED	20.0%	25.6%	19.4%	20.0%	19.9%	18.6%	15.1%	15.0%
- DISABLED	21.5%	26.7%	28.8%	30.4%	30.8%	28.8%	25.2%	24.8%
INDEPENDENT LAB								
- AGED	-1.1%	13.8%	58.9%	7.8%	8.7%	8.9%	8.2%	8.2%
- DISABLED	12.2%	24.2%	62.8%	7.8%	8.3%	8.8%	9.1%	9.0%

FY 1987

PEER REVIEW ORGANIZATIONS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
Decision Unit - PEER REVIEW ORGANIZATIONS

Analysis of Resources
(Dollars in Thousands)

Total Program Level:	FY 1985	FY 1986	FY 1987
Obligations	$152,342	$ 469,958	$ --
Outlays	$122,055	$ 180,988	$224,682

Total Program Level:	FY 1988	FY 1989	FY 1990	FY 1991
Obligations	$554,488	$ --	$653,009	$ --
Outlays	$245,276	$ 265,947	$288,541	$313,163

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

PEER REVIEW ORGANIZATIONS

Authorizing Legislation

Title XI, Part B, and Title XVIII, Section 1866, Social Security Act, as amended by the Social Security Amendments of 1983 (P.L. 98-21) and the Deficit Reduction Act of 1984 (P.L. 98-369).

Purpose and Method of Operations

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-248) provides, in Section 141 (the Peer Review Improvement Act of 1982), that the Health Care Financing Administration (HCFA) will contract with private utilization and quality control peer review organizations (PROs) to determine the medical necessity and quality of services provided under the Medicare Program. The Social Security Amendments of 1983 (P.L. 98-21) require the use of a prospective payment system (PPS) for Medicare inpatient hospital services. This system has wide-ranging impact upon the review activities pertaining to Medicare beneficiaries and requires that a hospital must maintain an agreement with a PRO if it is to be paid for services furnished to Medicare beneficiaries. The legislation further prescribes that costs supporting the PRO program "shall be transferred from the Federal Hospital Insurance Trust fund, without regard to amount appropriated in advance in Appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries."

The Social Security Act, Section 1153 (as amended), requires that the Secretary enter into biennial contracts with utilization and quality control organizations for the review of services rendered by physicians and other providers of health care services and of items for which payment may be made under the Medicare program. Section 602(f) of the Social Security Amendments of 1983 requires that hospitals receiving payments under subsections (c) or (d) of Section 1886 maintain an agreement with a utilization and quality control peer review organization (PRO) under which the PRO will review the validity of diagnostic information provided by such hospitals; the completeness, adequacy and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of care for which additional payments are sought under Section 1886(d)(5) (day and cost outliers).

Rationale for Federal Role

The monitoring activities conducted by PROs represent the primary Federal effort for assuring that Medicare beneficiaries are provided adequate care and that Medicare Trust Fund expenditures for such services are necessary. Actuarial estimates forecast that, in FY 1987, there will be 31.5 million enrollees in the Medicare Hospital Insurance (HI) program, who will generate HI benefit payments of approximately $52 billion. Most of this expenditure will pay for approximately 12.5 million admissions to acute care hospitals.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

PEER REVIEW ORGANIZATIONS

Authorizing Legislation

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Purpose and Method of Operations

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-248) provides, in Section 141 (the Peer Review Improvement Act of 1982), that the Health Care Financing Administration (HCFA) will contract with private utilization and quality control peer review organizations (PROs) to determine the medical necessity and quality of services provided under the Medicare Program. The Social Security Amendments of 1983 (P.L. 98-21) require the use of a prospective payment system (PPS) for Medicare inpatient hospital services. This system has wide-ranging impact upon the manner in which care is delivered to Medicare beneficiaries and requires that a hospital must maintain an agreement with a PRO if it is to be paid for services furnished to Medicare beneficiaries. The legislation further provides that costs supporting the PRO program "shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amount appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries."

The Social Security Act, Section 1153 (as amended), requires that the Secretary enter into contracts with utilization and quality control organizations for the review of services rendered by physicians and other providers of health care services and for items for which payment may be made under the Medicare program. Section 602(f) of the Social Security Amendments of 1983 requires that hospitals receiving payments under subsections (d) or (e) of Section 1886 maintain an agreement with a utilization and quality control peer review organization (PRO) under which the PRO will review the validity of diagnostic information provided by such hospitals, the completeness, adequacy and quality of care provided, the appropriateness of admissions and discharges and the appropriateness of care for which outlier payments are sought under Section 1886(d)(5) (day and cost outliers).

Rationale for Federal Role

The monitoring activities conducted by PROs represent the primary Federal effort for ensuring that Medicare beneficiaries are provided adequate care and that Medicare Trust Fund expenditures for such services are necessary. Actuarial estimates forecast that, in FY 1987, there will be 31.5 million enrollees in the Medicare Hospital Insurance (HI) program, who will generate HI benefit payments of approximately $[illegible] billion. Most of this expenditure will pay for approximately 11.6 million admissions to acute care hospitals.

The cost for health care benefit payments has increased at a percentage rate far in excess of inflation. In 1982, Congress reacted to these spiraling costs through passage of TEFRA legislation. This cost control activity was strengthened through the Social Security Amendments of 1983 which required implementation of a prospective payment system (PPS) for Medicare inpatient hospital reimbursement.

The PPS is being phased in over 3 years and affects most hospitals in the United States. The Social Security Amendments of 1983 provide for certain exceptions to the prospective payment method of reimbursement: psychiatric, rehabilitation and children's hospitals (including a distinct part of an otherwise affected hospital) together with hospitals in American Samoa, Guam, Puerto Rico and the Virgin Islands, which are not subject to this reimbursement system. Also, Medicare demonstration projects at the time of enactment of this legislation are exempt from the new system. There are four statewide demonstration projects: Maryland, Massachusetts, New Jersey, and New York. Sole community providers are also treated differently.

In monitoring PPS and PPS-exempt hospitals, the PROs must execute widely varying review methodologies to measure the appropriate use of Federal resources and carry out the review requirements of the law.

Relationship to Other Programs

The PRO program is closely linked in a number of ways with the Medicare contractor program. First, the Medicare contractors provide individual PROs with bill data and other information essential to the conduct of PRO reviews. Secondly, the Medicare contractors, in their medical review activity, exercise a role related to that of the PROs. No duplication, however, exists between the two programs. PROs are primarily responsible for peer review of inpatient hospital services; the Medicare contractors, for the medical review of Part A services not covered by the PROs (e.g., skilled nursing, home health) and Part B physician/supplier services.

In FY 1986, HCFA proposes to extend the scope of the PRO review to HMO services and outpatient surgery. These new review initiatives will not overlap with the medical review activity of the Medicare contractors. PRO review of HMO services will focus on quality of care issues not addressed by Medicare contractors. Likewise, PRO review of outpatient surgery procedures will examine areas not covered by Medicare contractor medical review.

PRO Objectives

PROs carry out numerous review activities including the requirement to validate diagnosis related group (DRG) assignments used for Medicare billings; conduct admission pattern monitoring (APM) of hospitals; perform review of a sample of all admissions to assure medical necessity and appropriateness for this level of care; review all hospital readmissions within 7 days; and review outliers, pacemaker implantations and transfers from a PPS hospital to either another hospital or to a PPS exempt psychiatric, rehabilitation or alcohol detoxification unit or to a swing-bed within the same hospital.

The following specific admission and procedure objectives are mandated under the PRO contractual arrangement:

+ Reduce admissions for procedures that could be performed effectively and with adequate assurance of patient safety in an ambulatory setting or on an outpatient basis.

+ Reduce the number of inappropriate or unnecessary admissions or procedures for specific DRGs.

+ Reduce the number of inappropriate or unnecessary admissions or procedures by specific practitioners or in specific hospitals.

In addition, PROs are required to review (1) atypical outlier cases; (2) each hospital denial; and (3) prior to hospital admission (in limited circumstances, this may include post-admission and pre-procedure), every elective case proposed for five procedure-related DRGs.

PROs must also achieve significant improvement in patient care quality by achieving quality objectives in the following categories:

+ Reduce unnecessary hospital readmissions resulting from substandard care provided during the prior admission.

+ Assure the provision of medical services which, when not performed, have significant potential for causing serious patient complications.

+ Reduce the incidence of mortality associated with selected procedures and/or conditions requiring hospitalization.

+ Reduce unnecessary surgery or other invasive procedures.

+ Reduce avoidable post-operative or other complications.

New Review Initiatives

Hospital Discharges

During early PPS implementation, there have been a number of reports of premature or inappropriate early discharges. To address the concern, HCFA will undertake studies to determine the appropriateness of the timing of patient discharges and develop ways to identify such instances. Activities will include the gathering and analysis of data in addition to the actual review of cases. These activities will be addressed separately from currently contracted PRO activities; however, the costs will be absorbed within the budget for inpatient hospital reviews.

In FY 1986, before the current round of PRO contracts expires, HCFA will conduct a number of pilot projects to address the issue of the premature discharge of Medicare patients by hospitals. The cost will be absorbed in the overall funding level

for inpatient hospital reviews.

Based upon the findings of these pilot studies, together with the review protocols developed for detection and review of suspect cases, HCFA intends to include this type of review to the range of activities covered by the second round of PRO contracts to be finalized near the end of FY 1986.

HMO Services

Increasing numbers of Medicare beneficiaries are expected to enroll in HMOs during the next few years as the Administration offers this option in place of the traditional reimbursed Medicare benefits package. For the beneficiary, there are significant advantages built into HMO plans which offer a wider range of health services and more predictable costs than under our more conventional health delivery system.

Beginning in FY 1986, HCFA will initiate PRO quality reviews of HMO services. These reviews will focus on a number of areas. Ambulatory records review of HMO Medicare beneficiaries will be conducted outside the hospital setting, either at the HMO facility or at the PRO site. PROs will perform quarterly reviews of the medical records of a sample of the HMO Medicare enrollees; monitor reports of premature discharge, inappropriate or inadequate treatment, delayed access to needed emergency care and problems concerning care provided out of area.

HMO quality reviews will be included in the range of activities covered by the second round of 2-year contracts to be finalized near the end of FY 1986. During the second round, PROs will be expected to accomplish the following workloads:

- approximately 113,500 reviews of HMO inpatient hospital services;
- approximately 97,000 reviews of HMO ambulatory services.

In addition, PROs will monitor complaints and process reconsiderations.

The cost associated with the review of HMO inpatient hospital services will be absorbed within the overall funding level for inpatient hospital reviews. Estimated cost for the review of HMO ambulatory services in the second round, including complaints monitoring and reconsiderations, is approximately $4.0 million.

Outpatient Surgery

PRO admission objectives, particularly admissions objective 1 and 2, shift procedures from an inpatient to an outpatient setting. Concern has been expressed that in effecting these shifts PROs have not monitored the quality of these services. There is also concern that surgeries determined to be unnecessary are being performed as outpatient services. To address these concerns, HCFA intends to conduct pilot tests of reviews of outpatient surgery. These tests will be conducted before the current round of PRO contracts expires.

Review protocols will be developed based upon the findings in these pilot tests.

Under this review initiative, PROs will be required to:

- determine whether the outpatient surgery was medically necessary;
- determine whether the preoperative risks were adequately evaluated and, therefore, the patient was treated in the appropriate setting;
- assure that charges were not inflated and unnecessary services (ancillaries, x-rays) were not provided to increase reimbursement; and
- assure that the quality of care met acceptable medical standards.

Aside from the issue of the quality of care provided, HCFA must provide oversight to deter inappropriate reimbursement. Outpatient hospital care is reimbursed on a cost basis by the fiscal intermediary. Thus, hospitals have an incentive to provide unnecessary ancillary services, x-rays, etc. There may also be an incentive for hospitals to encourage physicians to perform surgeries in the hospital outpatient department (including borderline cases which should be inpatient) to assure, if there are complications, hospital equipment is available and patient admission is easily accessible. In such cases, hospital reimbursement increases dramatically because, in addition to outpatient reimbursement, when such subsequent admission is necessary, the hospital generally receives DRG 468 payment.

Outpatient surgery reviews will be included in the range of activities covered by the next round of PRO contracts to be finalized near the end of FY 1986. The estimated 2-year cost for outpatient surgery reviews is $78.8 million. This estimate is based upon the following review levels:

- approximately 458,000 reviews of outpatient surgical procedures, listed under PRO objectives 1 and 2, which are being shifted from an inpatient to an outpatient setting;
- approximately 1,461,000 reviews of all other outpatient surgical procedures.

This level of effort will afford nearly a 20% coverage of all outpatient surgeries reimbursed under Medicare.

FY 1986 Round of PRO Contracts

All 54 PRO areas are scheduled for negotiation of new contracts prior to the close of FY 1986. It is assumed that many PRO contracts will be renewed and therefore competing bids will be far fewer in FY 1986 than encountered during the first round of funding.

The FY 1986 round of 2-year PRO contracts is estimated to cost $470.0 million. This funding level reflects:

- $387.2 million for inpatient hospital reviews;
- $4.0 million for review of HMO ambulatory services; and
- $78.8 million for outpatient surgery reviews.

Rationale for the Budget Request

PRO Inpatient Hospital Reviews

Funding requirements for PRO inpatient hospital reviews are mandated in Section 602(f) of P.L. 98-21:

> "...the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under Part A, and (i) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (ii) shall be transferred from the Federal Hospital Insurance Trust Fund, without regard to amounts appropriated in advance in Appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, (iii) shall not be less than an amount which reflects the rates per review established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation), and (iv) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1982 for direct and administrative costs (adjusted for inflation) of such reviews."

Thus, the Act authorizes the Secretary to establish a rate per review (unit cost) in an amount not less than an amount which reflects the rates per review established in fiscal year 1982 (adjusted for inflation). The unit cost rate applicable for FY 1982 was $11.67. The unit cost rates for subsequent years have been adjusted for inflation on the basis of the State and Local Purchasing Deflator. Admissions data are based upon actuarial projections contained in the FY 1985 Medicare Board of Trustees Report (updated by the Spring Review). The cost of inpatient hospital reviews is determined by multiplying the applicable unit cost rate times the number of estimated Medicare hospital admissions for a given year. The costs of inpatient hospital reviews, by fiscal year, are reflected in Table 1, Inpatient Hospital Review Costs.

TABLE 1

PEER REVIEW ORGANIZATIONS

INPATIENT HOSPITAL REVIEW COSTS

Fiscal Year	Number of Admissions (Thousands)	% Inflation Change From Previous Year	Unit Cost Rate	Cost ($ in Thousands)
1982	11,375	—	$11.67	$132,746
1983	11,914	6.7%	12.45	148,329
1984	11,718	4.1%	12.96	151,865
1985	11,857	4.9%	13.60	161,255
1986	12,089	4.8%	14.25	172,268
1987	12,478	4.6%	14.91	186,047
Outyear Projections				
1988	12,917	4.4%	15.57	$201,118
1989	13,353	4.0%	16.19	216,185
1990	13,827	3.7%	16.79	232,155
1991	14,341	3.7%	17.41	249,677

Specific obligation levels are based upon the costs for the two year period covered by the particular round of PRO contracts.

Example

The cost for inpatient hospital reviews during the second round of PRO contracts is computed as follows:

($ in thousands)

1987	$186,047
1988	201,118
Total	$387,165

HMO Reviews

Table 2 displays the costs for the review of HMO ambulatory services for fiscal years 1985-91. Cost estimates are based upon the expected number of HMO enrollees, utilization of HMO ambulatory services, and workloads associated with reconsiderations and complaints monitoring. Specific obligation levels are based upon the costs for the two year period covered by the particular round of PRO contracts.

Example

The cost for the review of HMO ambulatory services during the second round of PRO contracts is computed as follows:

($ in thousands)

1987	$ 1,819
1988	2,144
Total	$ 3,963

Costs associated with HMO inpatient hospital reviews will be absorbed in the budget for inpatient hospital reviews (Table 1).

TABLE 2

PEER REVIEW ORGANIZATIONS

HMO QUALITY REVIEW COSTS

Fiscal Year	Ambulatory Services			Recons	Total Cost
	# Reviews	Unit Cost	Cost		
1986	30,000	$34.40	$1,032,000	$200,000	$1,232,000
1987	45,000	35.98	1,619,100	200,000	1,819,100
1988	51,750	37.56	1,943,730	200,000	2,143,730
1989	57,512	39.06	2,246,419	200,000	2,446,419
1990	68,440	40.51	2,772,504	200,000	2,972,504
1991	78,750	42.01	3,308,288	200,000	3,508,288

OUTPATIENT SURGERY REVIEW COSTS

Fiscal Year	Outpatient Surgical Procedures (Objectives 1 and 2)			Other Outpatient Surgical Procedures			Total Cost
	# Reviews	Unit Cost	Cost	# Reviews	Unit Cost	Cost	
1986*	65,000	$ 38.40	$ 2,496,000	130,000	$38.40	$ 4,992,000	$ 7,488,000
1987	223,420	40.17	8,974,781	693,100	40.17	27,841,827	36,816,608
1988	234,590	41.93	9,836,359	767,410	41.93	32,177,501	42,013,860
1989	246,320	43.61	10,742,015	838,650	43.61	36,573,527	47,315,542
1990	258,640	45.22	11,695,701	922,515	45.22	41,716,128	53,411,829
1991	271,600	46.90	12,738,040	1,007,265	46.90	47,240,729	59,978,769

*FY 1986 pilot test.

Outpatient Surgery Reviews

Table 2 displays the cost for outpatient surgery reviews for fiscal years 1986-91. Cost estimates are based upon the expected outpatient claims workloads in the two areas covered by the review: (1) outpatient surgical procedures under PRO objectives 1 and 2 and (2) other outpatient surgical procedures. Specific obligation levels are based upon the costs for the two year period covered by the particular round of PRO contracts.

Example

The cost for outpatient surgery reviews during the second round of PRO contracts is computed as follows:

	($ in thousands)
1987	$ 36,817
1988	42,014
Total	$ 78,831

FY 1987

RESEARCH, DEMONSTRATION AND EVALUATION PROJECTS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Decision Unit- RESEARCH, DEMONSTRATION AND EVALUATION PROJECTS
(Budget Account 75-0511-0-1-550)

Analysis of Resources
(Dollars in Thousands)

Program Level:	FY 1985	FY 1986	FY 1987
Total Obligations	$ 34,000	$ 22,000	$ 33,000
Less Trust Fund Transfers	$ 11,650	$ 7,700	$ 11,000
Total Budget Authority	$ 22,350	$ 14,300	$ 22,000

Program Level:	FY 1988	FY 1989	FY 1990	FY 1991
Total Program Level	$ 34,320	$ 35,590	$ 36,800	$ 38,051

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
RESEARCH, DEMONSTRATION AND EVALUATION BUDGET

Authorizing Legislation - Social Security Act, Sections 1110, 1115, 1121(b)(2), 1875 and 1881(a); Rural Health Clinic Act, Section 3.

Purpose and Method of Operations - The Health Care Financing Administration's (HCFA) research, demonstration, and evaluation (RD&E) activities provide knowledge to enable the Administrator, the Secretary, Congress and other interested parties to make informed and rational decisions regarding HCFA program and policies.

For a substantial period of time, the costs of health care services have been increasing more rapidly than the general economy. This means that not only has the absolute number of dollars spent on health care increased rapidly, but also that the proportion of the Gross National Product related to health care has increased. This long-range trend is, and has been, a matter of primary concern to HCFA as the leading purchaser of health care in the United States. Since the inception of HCFA the overall purpose of the RD&E program has been to find ways to moderate or control this inflationary trend and to insure that every dollar was used effectively in the service of HCFA beneficiaries.

HCFA's existing research, demonstration, and evaluation activities include projects to test new reimbursement, coverage, eligibility, and program management approaches as well as research and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to health care services, and the economics of the health care industry. HCFA is extensively involved in the creation of new and improved data sets to support these ongoing research and demonstration activities. These projects result in knowledge about the basic structure, incentives, costs, and effects of HCFA programs and policies and make it possible to refine existing policies, simulate or test various program changes on a trial basis, and develop innovative financing and delivery systems.

Research on hospital classification and case-mix provided a basis for Medicare reimbursement reform, beginning with refinements to routine per diem cost limits and leading to expanded total case limits. Finally, the RD&E investment provided the basis for the most significant program reform since the inception of the Medicare program--the prospective payment system based on a diagnosis-related groups (DRG) approach. Demonstration and evaluation activities proved the feasibility of this payment system in containing health care costs and developed tested methods to facilitate nationwide implementation. This prospective payment system is expected to result in significant and ongoing savings to Medicare through the provision of financial incentives to encourage efficient health care delivery. The RD&E program is currently engaged in a major set of projects related to the evaluation, refinement, and extension of PPS.

HCFA's RD&E program has provided the basis for other program reforms such as prospective payment for HMOs under Medicare; extended coverage of cost-efficient providers such as ambulatory surgery centers and swing-beds in rural hospitals, and coverage of systems for community-based care as alternatives to expensive institutionalization. Without these RD&E activities, HCFA would not have the data base and factual experience necessary to develop succesful legislative, policy, and program reform proposals related to PPS impact, refinement, and extensions to other areas.

Over the past several fiscal years, the RD&E program has slowly changed its focus so that the majority of its efforts have gone to projects that had a relatively short-range impact. This was driven by the Administration's needs in the final stages of the preparation of the Medicare hospital prospective payment system and more recently by the numerous questions about, and congressionally mandated studies of, various aspects of the system. As a result, our medium to long-range projects were significantly curtailed, even though many projects which had such origin have recently been the basis for major program changes, such as the hospital prospective payment system. While some of the short-range emphasis needs to continue into FY 1987, we believe that it is imperative to bring back the focus on medium and long-range subjects that can lead us through the next evolution of program changes. This adjustment does not cause a noticeable shift in the budget by priority area in this presentation, but over time, it will change the type of projects the RD&E program undertakes.

Rationale for Federal Role - HCFA's RD&E activities are focused in areas that are applicable to the Medicare and Medicaid programs. Because Federal expenditures under these programs are estimated at more than $100 billion in FY 1987, there is a significant Federal interest in the development and testing of alternatives to administer these programs in more efficient and cost-effective ways. HCFA's RD&E program has produced results that have saved substantially more in program dollars than the cost of the RD&E. In addition, Congress has repeatedly recognized the importance of this role by requiring that potential program changes be investigated by means of demonstrations before the enactment of full-scale legislative program changes and by mandating reports relative to program implementation (e.g., hospital prospective payment, swing-bed and hospice programs).

Furthermore, the existing focus of the RD&E program needs to be broadened so that a significant proportion of the effort is directed towards data, studies, experiments and demonstrations that help to specify and then to implement major reforms of existing programs. The work on Medicare's hospital prospective payment system (enacted and implemented in 1983) had its beginning in the mid 1970s with the last 2 years prior to implementation being devoted to resolving detailed issues within the DRG approach. Thus, the lead time on this change in the

way we pay hospitals was 8-10 years. Starting now, but with growing emphasis in FY 1987, we want to work on projects that may lead to major change in the entire health care delivery system in the 1990s. If the past is an indication, this may require a refocusing of data design and development in areas that have not been needed before. It will also mean a variety of experiments and demonstrations to test alternate approaches to the same problem. This will be followed by more detailed projects as the professional (and public) discussion begins to narrow toward the specific changes that might be appropriate.

Rationale for the Budget Request - The fiscal year 1987 request for funding of HCFA's research, demonstration, and evaluation activities is $33,000,000. The budget proposed for fiscal year 1987 represents a continuation of already approved research, demonstration, and evaluation activities; support of projects and studies mandated by Congress; and initiation of new projects identified as being policy relevant. The priorities for this budget were established through a collaborative process involving HCFA senior level staff, administration policymakers, Congressional staff, health care providers, and beneficiary groups.

HCFA's research, demonstration, and evaluation projects are conducted in seven program (priority) areas. A general overview of the specific activities to be conducted in each of the seven priority areas during fiscal year 1987, as well as the funding by priority area, the overall goal within the priority area, the rationale for the proposed work, and our strategy for reaching the stated goal follow. We have revised the priority areas to combine program analysis/evaluation with quality of care, since these are so closely related, and to emphasize our interest in technology by adding it to the coverage priority area to which this is closely related. The priority areas are:

Hospital Payment
Physician Payment
State Programs for Long-Term Care
Alternative Payment Systems
Program Analysis, Evaluation, and Quality of Care
Technology and Coverage
Beneficiary Awareness and Prevention

The budget reflects the large number of congressionally-mandated research, demonstration, and evaluation projects. Our estimates at this time, are that during fiscal year 1987 we will spend $10,751,000 for these projects. A breakout by priority area of congressionally mandated activities follows:

o Hospital Payment	$6,720,000

Projects that will study the impact of the Medicare prospective payment system on beneficiaries and providers and which will assist in the refinement and extension of the prospective payment system as mandated by the Social Security Amendments of 1983 (P.L. 98-21) and the Deficit Reduction Act of 1984 (P.L. 98-369). Projects that will develop, demonstrate, and evaluate the feasibility of a prospective payment system for skilled nursing facilities as mandated by section 101 of P.L. 97-248 and section 2319(f) of P.L. 98-369; and of alternative payment systems for home health agencies as mandated by P.L. 97-414 (Orphan Drug Act). Projects that evaluate the Medicare hospice program as mandated by P.L. 97-248.

way we pay hospitals was 5-10 years. Starting now, but with growing emphasis in FY 1985, we want to work on projects that may lead to major change in the entire health care delivery system in the 1990s. If the past is an indication, this may require a refocusing of data design and development in areas that have not been needed to date. It will also mean a variety of experiments and demonstrations to test alternate approaches to the same problem. This will be followed by more detailed projects in the problem area and public discussion leading us to [illegible] toward the specific changes that might be appropriate.

Rationale for the Budget Request – The fiscal year 1985 request for funding of HCFA's research, demonstration, and evaluation activities is $[illegible]. The budget proposed for fiscal year 1985 represents a continuation of the [illegible] approved research, demonstration, and evaluation [illegible] scope of projects and studies mandated by Congress and initiation of new projects identified to have policy relevance. The priorities for this budget were established through a deliberative process involving HCFA senior level staff, administration policymakers, Congressional staff, health care providers, and beneficiary groups.

HCFA's research, demonstration, and evaluation projects are organized in seven priority areas. A general overview of the specific activities to be conducted in each of the seven priority areas during fiscal year 1985 as well as the funding for each priority area, the overall goal for each priority area, the rationale for the proposed work, and our strategy for achieving the stated goals, follows. We have revised the priority areas to combine program [illegible] and quality of care [illegible] these areas are as recently [illegible] and an emphasis [illegible] by putting it in the [illegible] stated. They are as follows:

Hospital Payment
Physician Payment
State Programs for Long-Term Care
Alternative Payment Systems
Program Analysis, Evaluation, and Quality of Care
Technology and Coverage
Beneficiary Assessment and Protection

The budget reflects the large number of congressionally mandated research, demonstration, and evaluation projects. On the basis of [illegible] at this time, we find that during fiscal year 1984 we will spend $[illegible] for these projects. A breakdown by priority area of congressionally mandated activities follows:

o Hospital Payment $[illegible]

Projects that will study the impact of the Medicare prospective payment system on beneficiaries and providers and which will assist in the refinement and extension of the prospective payment system as mandated by the Social Security Amendments of 1983 (P.L. 98-21) and the Deficit Reduction Act of 1984 (P.L. 98-369). Projects that will develop, demonstrate, and evaluate the feasibility of a prospective payment system for skilled nursing facilities as mandated by section 101 of P.L. 97-248 and section [illegible] of P.L. 98-369, and of alternative payment systems for home health agencies as mandated by P.L. [illegible]. Projects that evaluate the Medicare hospice program as mandated by P.L. 97-248.

- Physician Payment $1,500,000

  Projects that will develop, demonstrate, and evaluate the feasibility of combined physician/hospital DRG payment as mandated by section 2317 of P.L. 98-21, amended by P.L. 98-369.

- Alternative Payment Systems $1,100,000

  Projects that study the feasibility and desirability of health status or disability adjustments to the adjusted average per capita cost methodology as mandated by P.L. 97-248. Projects which demonstrate and evaluate the social health maintenance organization concept as mandated by P.L. 98-369.

- Program Analysis, Evaluation, and Quality of Care $1,331,000

  Projects that study the impact of the Prospective Payment System on quality of care as mandated by P.L. 98-21.

- Technology and Coverage $100,000

  Projects that study the efficacy and cost-effectiveness of nutritional therapy in treating chronic renal disease as mandated by P.L. 96-499.

A general overview of the specific activities to be conducted in each of the seven priority areas during fiscal year 1987, as well as the funding by priority area, follows:

HOSPITAL PAYMENT **$12,470,000**

GOAL: To further refine, evaluate and expand the Medicare prospective payment system for hospitals as an alternative to cost-based reimbursement under Medicare and Medicaid without sacrificing the quality of care. To study cost-effective alternatives for payment of other acute care under Medicare and Medicaid without sacrificing the quality of care.

RATIONALE: The Social Security Amendments of 1983 (P.L. 98-21) established a prospective payment system (PPS) for most hospitals participating in the Medicare program. Section 603 of P.L. 98-21 included a Congressional mandate to study a number of issues relating to PPS, including the impact of PPS on health care delivery and financing systems, and on other third-party payors, the refinement of case-mix reimbursement. In addition, the Deficit Reduction Act of 1984 (P.L. 98-369) added to the number of Congressionally-mandated studies, reflecting a continuing need for improved understanding of the impact of PPS and of specific issues within PPS.

Also of major importance to the Medicare program, in terms of cost effectiveness and quality of care, is the study of the expansion of PPS to include the payment of physician services for inpatient care on a per case basis, and the combination of payment for acute care and post-hospital care.

STRATEGY: Section 603(a) of P.L. 98-21 and other legislation mandated a series of studies on issues for refinement of the prospective payment system. We will be conducting both intramural and extramural projects on these issues to meet the Congressional mandates, including studies to refine severity of illness measures, adapt current data for use in PPS recalibration, and refine case-mix measures; the impact of PPS on hospitals participating in clinical trials; and PPS impact on hospital support services such as the blood banking industry.

Section 603(a) also requires the Secretary to report annually on the impact of the prospective payment system during the previous year on classes of hospitals, beneficiaries, other payors of inpatient hospital services, other providers, etc. We will continue to study the impact of the prospective payment system on quality of care, hospital behavior, cost of care, and discharge and admission patterns. That section also requires a report on the impact of alternative State hospital payment systems under waiver from PPS. There are a number of Statewide or areawide Medicare hospital payment demonstrations currently in operation. A number of these systems have transitioned to either the Medicare PPS or to the program waiver authority under section 1886(c) of the Social Security Act. We will continue to study State hospital payment system demonstrations that differ from the Medicare PPS to determine their cost effectiveness.

Congress mandated that the Department study the feasibility of including payment to physicians for services provided to hospital inpatients in the DRG amounts (section 603(a)(2)(b) of P.L. 98-21, amended by section 2317 of P.L. 98-369). In addition, the Department is required (by section 101 of P.L. 97-248 and section 2319(f)(1) of P.L. 98-369) to report to Congress on the range of options available for prospective payment for SNFs, including the feasibility of permitting inclusion of payments to hospital-based facilities within the Medicare DRG amounts.

Because of the potential for cost-savings and efficiency such "bundling" of services has for payment purposes, we will continue our efforts in studying, developing, demonstrating, and evaluating various alternatives for expanding the Medicare PPS to include sub-acute care including:

- developing a DRG-type system that combines payment for acute care and skilled nursing care; and
- developing a DRG-type system that combines payment for acute care and physician services to hospital inpatients or pays for physician inpatient services separately, but on a per case basis.

In addition to the congressionally mandated studies with respect to combined hospital-SNF and hospital-physician payment systems, we also plan to:

a. study the feasibility of a hospital outpatient department PPS;
b. analyze and study hospital outpatient cost and unit service costs; and
c. continue our demonstration and evaluation of prospective payment mechanisms for Home Health Agencies.

Finally, we also plan to initiate our study of competitive bidding as an alternative to the Medicare hospital payment system.

PHYSICIAN PAYMENT $3,650,000

GOAL: To identify, develop, demonstrate, and evaluate effective alternatives to control the costs of physician reimbursement under Medicare and Medicaid without sacrificing the quality of care.

RATIONALE: The current systems used under the Medicare and Medicaid programs to reimburse physicians promote inefficiencies in the use of health care resources and result in inefficiencies in physician payment levels and beneficiary out-of-pocket expenditures.

Previous research studies have documented that the current payment systems do not encourage physician participation in Medicare and Medicaid, are complicated to administer, are not readily understood by physicians and beneficiaries, and do not promote cost-conscious medical decisions. The system encourages physicians to specialize, to practice in urban and suburban areas, and to perform services in hospital settings. P.L. 98-369 addressed these matters by freezing physician fees instituting a Medicare participating physician program, and directing the Department to report sooner on the physician DRG issue.

STRATEGY: Changes in the current physician reimbursement system are necessary to reverse the inflationary incentives in the current system and create incentives for efficiency and lower charges while ensuring continued access to high quality care. Such a system should be easier to understand and simpler to administer than the current system, and should be implementable, at least in part, in the near future. The system should also make Government outlays and provider revenues predictable, prevent transfer of burdens to beneficiaries, and establish the Federal Government as a prudent purchaser.

As mentioned in the Hospital Payment area, Congress mandated that the Department study the feasibility of including payment to physicians for services provided to hospital inpatients in the hospital DRG amounts (section 603(a)(2)(b) of P.L. 98-21, amended by section 2317 of P.L. 98-369).

We plan to extend our study of this "bundling" of procedures concept for physician payment purposes to the non-hospital setting as well.

In order to further study the feasibility and desirability of "bundling" services for physician purposes, we plan to continue to develop a physician data base using survey data (such as the survey of physician practices costs and income), samples from carriers, and research data in order to permit the reliable application of statistical methods for research and policy simulation and analysis.

Once we have identified potential methods of bundling services (both in the inpatient hospital setting and in the non-hospital setting) we will continue to develop, demonstrate, and evaluate proposals to test alternative payment systems for physician services including the following efforts:

- Study extension of the Medicare hospital DRGs to incorporate payments for physician services provided to inpatients;
- Encourage demonstration projects to test alternative payment systems for non-hospital physician services, including approaches which combine all Medicare Part B services into a stand-alone prospective payment scheme, such as negotiated fee schedules, competitive bidding for services, capitation payment by type of case, special physician participation arrangements or carriers at risk.

In addition, we will continue our efforts in the development and refinement of relative value scale (RVS) as the basis for physician payments, at least as an intermediate measure. (Note: The relative value scale is a table of weights which defines the relative prices of procedures; a conversion factor changes the relative value scale into a dollar price and thus converts the RVS into a fee schedule.)

In addition, to assist in further refining our information base as we move toward some form of capitation system for physician services, we will also study factors influencing rates at which physicians participate, or otherwise accept assignment of Medicare claims; and evaluate the impact of case-management systems on utilization, costs, and quality of care.

STATE PROGRAMS FOR LONG-TERM CARE $2,557,000

GOAL: To participate with States and localities in identifying, developing, demonstrating, and evaluating effective alternatives to control the costs of long-term care reimbursement under the Medicaid program without sacrificing the quality of care.

RATIONALE: Medicaid is a principal source of funding for long-term care in the United States. Between 1973 and 1981, long-term care expenditures for aged and developmentally disabled persons under Medicaid increased from $3.4 billion to $13.3 billion, an average annual rate of increase of 18.5 percent. This growth rate is likely to continue to increase in the future, due in part to demographic trends.

Because the Federal Government shares in the funding of the Medicaid program, and in view of the anticipated growth in costs, we share the States particular interest in State and locality-developed projects that would design and test alternatives to the current long-term care delivery and financing systems.

STRATEGY: In response to the increasing demands being made on the long-term care delivery and financing system, and to the move away from the traditional institutional approach toward caring for the needs of the elderly in the community, we share the States' interest in taking actions aimed at furthering our mutual understanding of the characteristics and needs of the existing long-term care population and developing alternatives to the existing reimbursement and delivery systems.

We plan to continue to develop data and information bases that provide a deeper understanding of the aged population and its social (family, community, financial) setting, and that permit analysis, and policy and research simulation.

We also share the States' interest in identifying, developing, demonstrating, and evaluating cost-effective alternative payment and delivery systems for long-term care which ensure continued access by beneficiaries to quality health care.

In addition to identifying cost-effective alternative financing and delivery systems, States have also expressed a desire to identify, study, and develop family and community support programs that forestall premature or unnecessary institutionalization, and maintain the independence, health, and well-being of individuals.

ALTERNATIVE PAYMENT SYSTEMS $8,200,000

GOAL: To identify, develop, demonstrate, and evaluate effective alternative health care delivery and/or payment systems to control costs of reimbursement under the Medicare and Medicaid programs without sacrificing the quality of care.

RATIONALE: Prior research and demonstration activities involving the Medicare and Medicaid programs, which focused primarily on health maintenance organizations (HMOs), determined that alternative delivery systems and alternative risk reimbursement mechanisms are cost-effective and offer Medicare and Medicaid beneficiaries the opportunity for improved benefits over the existing fee-for-service system.

There is a need to go beyond HMO and competitive medical plan designs and test other delivery and financing systems that enhance competition among providers and yield potential savings to the program.

STRATEGY: This priority area cross-cuts several other areas (Hospital Payment, Physician Payment, State Programs for Long-Term Care). However, projects under this area tend to include more than one segment of the Medicare/Medicaid population or one aspect of the health care delivery/financing system. Within this area, we are attempting to identify, test, and evaluate cost-effective alternative delivery and/or financing systems which impact on multiple segments of the programs. Therefore, we are particularly interested in focusing our efforts in this area on those projects designed to test systems capitating payments for various types of services (such as home health agencies, HMOs, S/HMOs, the Arizona Health Care Cost Containment System) and those projects which seek to refine or test alternatives to the current methods and bases for payment to capitated systems.

We are specifically interested in identifying cost-effective service delivery and reimbursement alternatives, and demonstrating and evaluating these promising options to determine their cost-effectiveness, impact on quality of care, and impact of utilization and choice of services. Specific activities which are anticipated are as follows:

+ We want to demonstrate and evaluate projects which pay for services under Medicare and/or Medicaid on a capitation basis to gain a better understanding of the impact of such systems on quality of care, cost and utilization of services, and the health care delivery patterns of providers;
+ We plan to continue to demonstrate and evaluate the social health maintenance organization concept as required by section 2355 of P.L. 98-369, to study a capitated delivery/financing system which integrates health and social services under the direct management of the provider of services;
+ We plan to demonstrate and evaluate the intermediary-at-risk concept whereby reimbursement for Medicare Part A, Part B, or Parts A and B services, as well as costs for all administrative services, would be capitated for all beneficiaries in a specific geographic area;
+ We plan to continue to demonstrate and evaluate systems which pay for home health services priced through a competitive bidding process;
+ We plan to develop and refine patient specific case-mix measures for post-hospital care;
+ We plan to continue our efforts to demonstrate and evaluate payment systems for end-stage renal disease (ESRD) services, such as capitation and competitive bidding, as an alternative to the current ESRD payment system to determine the cost-effectiveness and impact on quality and delivery of services of such a system;
+ We plan to continue our efforts to demonstrate and evaluate competitive models for clinical laboratory services and durable medical equipment as an alternative to the current financing system;
+ We will continue to demonstrate and evaluate the Arizona Health Care Cost Containment System as a capitated health care delivery system;
+ We plan to increase our efforts in the design, development, demonstration, and evaluation of projects under which vouchers are provided directly to Medicare and/or Medicaid beneficiaries in a specific geographic area for the purchase of health benefits. We see voucher systems as next logical step from capitated systems, as well as an extension of our effort to "bundle" services for payment purposes, and as potential cost-effective methods to deliver and reimburse for health care services under Medicare and Medicaid; and
+ We plan to conduct a demonstration and evaluation of a Medicaid capitated system whereby physician case-managers will be at risk for expenditures in excess of the capitation payment.

Medicare reimbursement to HMOs is based on the adjusted average per capita cost (AAPCC) formula, which uses age, sex, welfare status, and institutional status as factors to predict the per capita amount that would be payable if Medicare services for HMO members were furnished in a fee-for-service market. Section 114 of P.L. 97-248 refers to age, disability status, and such other factors as the Secretary determines appropriate to ensure the soundness of the AAPCC methodology. In addition, the Conference Committee Report accompanying P.L. 97-248 also mentions an adjustment for health status. A number of studies have

suggested that there has been biased selection of healthier than average persons into HMOs and that the current AAPCC does not adequately adjust for this selection. For this reason, in order to determine whether the AAPCC needs to be refined, we plan to continue our study of possible adjustments to the AAPCC. Factors under study include prior health services use as a proxy of health status, former entitlement to SSA disability, hospital diagnosis, functional status, and self-reported measures of health. We plan to conduct demonstrations that test adjustments to the AAPCC to determine their effectiveness in refining the methodology.

PROGRAM ANALYSIS, EVALUATION, AND QUALITY OF CARE $4,670,000

GOAL: To further improve our knowledge and understanding of, as well as our ability to analyze, the impact of program changes and the factors influencing program performance and to ensure the maintenance of quality of care under the programs.

RATIONALE: Congress has promoted major changes in the past few years to improve the effectiveness and efficiency of the Medicare and Medicaid programs. Research on and evaluation of these changes, as well as factors influencing program performance, provide the information on health care expenditures and utilization patterns of Medicare and Medicaid beneficiaries necessary to achieve more cost-effective program operations. Program changes have the potential to impact on the quality of care provided to program beneficiaries. Valid quality of care measures are necessary in order to be able to assess and ensure the maintenance of quality health care under the programs.

STRATEGY: Our efforts in this area are intended to provide the information on health care expenditures and utilization patterns of Medicare/Medicaid beneficiaries necessary to achieve more effective program operations. Essential to this effort is the improvement of existing Medicare and Medicaid data bases.

We also plan to continue our efforts aimed at evaluation of major changes in the Medicare and Medicaid programs in order to determine the impact of these changes, as well as to provide the information necessary to determine how we might improve program performance in these areas.

We also plan to study important aspects of program performance in order to gain a better understanding of the factors influencing utilization of particular types of services, of the characteristics of certain categories of beneficiaries, and of the characteristics of certain aspects of the programs. Specific activities include the following:

+ Study of geographic variation in medical use and costs to understand better the factors influencing utilization patterns and factors influencing costs of services; and
+ Study of the "cross-over" population which uses Medicare and Medicaid to understand better the characteristics of this segment of the Medicare/Medicaid population.
+ Analysis of the effects of various payment mechanisms upon the use of different sites for delivery of covered health care services.

Program changes such as the Medicare hospital PPS have the potential to impact (both favorably and unfavorably) on the quality of care provided to program beneficiaries. In order to assess the impact of such changes, as well as to ensure the continuation of quality care provided to program beneficiaries, it is essential that we develop and refine valid quality of care measures for different treatment settings. Anticipated activities include the following:

+ Refine hospital quality of care measures for use in determing absolute levels of quality and changes in quality over time; and
+ Develop measures of appropriateness and quality of care for sub-acute care.

TECHNOLOGY AND COVERAGE $853,000

GOAL: To assess the costs and benefits of coverage of new procedures, treatments, and services under the Medicare and Medicaid programs.

RATIONALE: Medical knowledge and technology development continue at an accelerated rate. Expansion of Medicare and Medicaid coverage to include new benefits or services, particularly in high cost areas, is an important policy decision because of the high potential costs to the programs.

STRATEGY: It is imperative that we study selected technology and Medicare and Medicaid coverage issues to determine the impact of expanding coverage, as well as the potential impact of new technologies on treatment and service utilization for particular segments of the Medicare/Medicaid population. Therefore, we plan to continue and expand our efforts in the following areas:

+ We plan to study survival rates of end-stage renal disease patients, particularly focusing on the impact of treatment modalities on survival rates;
+ We plan to implement a systematic approach for HCFA to use in assessing coverage and reimbursement issues on new or controversial technologies;
+ We plan to continue our study of the cost effectiveness of nutritional therapy in delaying the need for renal dialysis;
+ We plan to continue our study of the effectiveness of behavior modification as a means of curing incontinence in the elderly;
+ We plan to demonstrate and evaluate the effects of providing supports to families who are maintaining the frail elderly at home.

- Study of geographic variation in medical use and costs to understand better the factors influencing utilization patterns and factors influencing costs of services; and
- Study of the "cross-over" population which uses Medicare and Medicaid to understand better the characteristics of this segment of the Medicare/Medicaid population.
- Analysis of the effects of various payment mechanisms upon the use of different sites for delivery of covered health care services.

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TECHNOLOGY AND COVERAGE $85,000

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- We plan to demonstrate and evaluate the effects of providing supports to families who are maintaining the frail elderly at home.

BENEFICIARY AWARENESS AND PREVENTION $600,000

GOAL: To test the cost-effectiveness of covering under Medicare and/or Medicaid such preventive services as immunizations, screening, testing, and health education services.

RATIONALE: There is a body of literature which indicates that spending for preventive health care services will reduce overall spending in the long run. Despite this evidence, Medicare, many State Medicaid programs, and other third-party payors cover few preventive care services.

STRATEGY: As part of our long-range efforts to study and move toward some form of voucher system for reimbursing for health care services, it is imperative that we conduct studies of the extent of understanding beneficiaries have with regard to the program, and the impact beneficiary awareness/education efforts have on program understanding, selection of health care alternatives, and selection of treatment modalities.

In addition, because of the potential cost-effectiveness of preventive services, and the impact such services may have on long-term beneficiary health and wellness, it is essential that we identify those services which may prove cost-effective as preventive services, study the effectiveness of these services in controlling health care costs, and study the most appropriate coverage/financing policies with respect to the services. This will include studies which demonstrate and evaluate the extent to which preventive services and patient education efforts prevent, control, delay, or reduce morbidity from chronic diseases, and reduce the overall cost of health care under the Medicare and Medicaid programs.

PROGRAM HIGHLIGHTS AND ACCOMPLISHMENTS

1. Hospital Payment

- Research on hospital classification and case-mix provided a basis for Medicare reimbursement reform, beginning with refinements to routine per diem cost limits, leading to expanded total case limits, and resulting in the prospective payment system for hospitals based on diagnosis-related groups.

- The studies mandated by the Social Security Amendments of 1983 (the Prospective Payment System (PPS) legislation) will resolve many of the remaining issues and provide policymakers with current information on the progress of the system.

- Research has continued on the testing of alternative hospital prospective payment systems with the implementation of two demonstrations in Massachusetts and New York. These experiments can serve as test sites for the refinement of reimbursement methodologies, such as outpatient payment, before they are considered for use in the Medicare prospective payment system.

- A method was devised to detect providers who may be unnecessarily increasing admissions in order to take advantage of the new reimbursement rules under PPS.

- Prior to passage of the PPS legislation, HCFA's R&D resulted in a number of major modifications in hospital cost-reimbursement policy, producing significant program savings. Examples of these changes included elimination of the private room differential under Medicare, elimination of the 8.5 percent Medicare routine nursing differential, and reductions in Medicare and Medicaid payments to hospitals for malpractice insurance. These three reforms were estimated to save $800 million in program costs based on actuarial projections for FY 1984.

2. Physician Payment

- o HCFA is working on physician reimbursement methods that will provide alternatives that do not increase inflation as does the current fee-for-service system.

- o Data from the Physician Survey has been used to update and refine the Medicare Economic Index. We estimate that this index has resulted in a 3.5 percent saving in Medicare reimbursements.

- o The survey results have also been analyzed to aid in understanding why some physicians elected to become Medicare participating physicians while others did not, how Medicare's hospital PPS affected physician's practices, the extent to which physicians now participate in various kinds of alternative health plans including why or why not.

- o HCFA studies have documented that the current method of Medicare reimbursement results in excessive payments to certain physicians. This evidence has supported provisions in P.L. 97-248 to change reimbursement policy for provider-based physicians, inpatient radiologists, physicians providing services in outpatient departments, and assistants in surgery.

- o Work is currently underway to support the development of an inpatient physician DRG payment system.

- o The expanded Medicare Part B Data Base is being examined to show the extent of volume and intensity changes that occured during the physician fee freeze or that result from the Medicare Participating Physicians Program.

3. State Programs for Long-Term Care

- o Community care demonstration experience provided a basis for the provisions in the Omnibus Budget Reconciliation Act of 1983 that authorize Medicaid waivers for States to provide home and community-based care services.

- o HCFA research based on data from a number of states has shown that case-mix differences explain a significant proportion (30-40 percent) of the variation in the per diem costs of nursing homes. These results imply that case-mix differences should be taken into account in developing Medicare prospective payment systems for nursing homes.

- o Interim results of research on the impact of a State's pre-admission screening program for nursing home placement found no detrimental effects of the program, such as increases in mortality or declines in functional status, during the 18-month study period. The program appeared to be a cost-effective means of reducing institutionalization in nursing homes.

4. Alternative Payment Systems

- Medicare competitive health care demonstrations, initiated in 1983 and 1984, are testing various models including HMOs, private insurers utilizing preferred provider organizations, networks of Individual Practitioner Associations utilizing a common risk reserve, and a broker to perform centralized enrollment and areawide marketing of alternative health plans.

- The results and experience from prospective HMO demonstrations supported the adoption of the new provision in P.L. 97-248 and provide the tested systems necessary for implementation. An evaluation contract has been awarded to assess the pre- and post-TEFRA experience of these sites.

- HMO demonstrations have shown that Medicare beneficiaries will enroll in comprehensive health plans if incentives such as additional benefits are provided. More than 200,000 Medicare beneficiaries have enrolled in alternative delivery systems that are prospectively reimbursed.

- HCFA research activities resulted in the development of a model to improve the accuracy of the AAPCC by including prior use of health care services. This model is being tested in a HMO demonstration in Minnesota.

- HCFA funded development and implementation of Medicaid competition models in five States (New York, New Jersey, Missouri, Florida, and Minnesota) to examine the effects of consumer choice models, case-managed models, and county-at-risk models. To date, three States have initiated services under the new models and have enrolled 55,000 Medicaid recipients.

- The Arizona Health Care Cost Containment System (AHCCCS) demonstration was implemented in October 1982. This project incorporates a competitive model based on capitated payment by HCFA to the State, a competitive bidding process, and prepaid capitated financing to providers. The State has completed 3 years of selection of providers through competitive bidding.

- Evaluation contracts have been awarded for the two alternative health plan competition demonstrations (Medicaid and Arizona Health Care Cost Containment System). These evaluations are assessing the impact of alternative health plans operating in a competitive environment on use and cost of services, access to services, consumer choice, and quality of care. In addition, the evaluations will address biased selection issues and alternative health plan marketing.

- An ESRD competitive bidding demonstration was successfully implemented in Denver Standard Metropolitan Statistical Area (SMSA). One facility submitted a bid of $12 below the composite rate. Beneficiaries will be eligible to receive an incentive payment of $8.40 if they choose that facility.

5. Program Analysis, Evaluation and Quality of Care

- o Field work for the first National Medical Care Utilization and Expenditure Survey (NMCUES) is complete. This survey was jointly sponsored by HCFA and the Public Health Service. Reports published in FYs 1983, 1984 and 1985 will permit analysis of HCFA beneficiary utilization and expenditures for health care by demographic characteristics. To summarize the numerous findings from NMCUES, a compendium of results and analyses is being developed for publication.

- o Person-level Medicaid data for 1980, 1981 and 1982 have been obtained from five State Medicaid agencies. These data have been processed to produce a set of "uniform" research data files. Tabulations are available for Medicaid enrollment, use, and expenditures in selected States. The data system will be used for program management and policy analysis at the State and Federal levels. The data will also support HCFA's Medicaid program evaluation in the areas of home and community-based care, inpatient hospital reimbursement, freedom of choice, cost-sharing, and eligibility.

- o Analysis of Medicare use by aged persons entitled to both Medicare and Medicaid shows that about 13 percent of the aged population have dual entitlement. Both Medicare per capita reimbursements and mortality rates were 50 percent higher for the dually entitled, compared with other enrollees, which illustrates the poorer health status of the dually entitled.

  A second study of the dually entitled showed that not only the medically needy but the cash assistance aged were in substantially poorer health than the average aged person.

- o HCFA research indicated that the Medicare Part 3 fixed-price contract experiments in Maine, Illinois, and upstate New York reduced Federal costs for carrier services. The decreased costs occurred without any significant adverse effects and are attributable to less expensive processing sites, improved processing systems, and economies of scale.

- o Two major studies of the ESRD population were completed. The first focused on the incidence and prevalence of the disease, and the second analyzed the use and cost of various modalities of care.

6. Technology and Coverage

- o A demonstration project has been initiated to determine the extent to which nutritional therapy in early renal failure can retard the progression of the disease. An interagency agreement between HCFA and the National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases will be used to implement this study.

7. Beneficiary Awareness and Prevention

- The Medicaid California Obstetrical Access Demonstration was designed to test the effects of providing early obstetrical care on the subsequent morbidity and mortality of low-income pregnant women in California. Preliminary data suggests that early comprehensive health care services to low-income pregnant women can lower infant mortality and premature deliveries and reduce the incidence of low-birth-weight infants.

FY 1987

MEDICARE CONTRACTORS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Decision Unit - MEDICARE CONTRACTORS
(Budget Account 75-0511-0-1-550)

Analysis of Resources
(Dollars in Thousands)

Total Program Level:	FY 1985	FY 1986	FY 1987
Total Obligations	$ 932,600	$ 935,000	$1,056,100
Contingency Fund:			
Operating	(4,000)	--	(20,000)
Legislative	--	(15,000)	(18,700)

Total Program Level:	FY 1988	FY 1989	FY 1990	FY 1991
Total Obligations	$ 1,098,000	$1,142,900	$1,180,700	$1,220,800
Contingency Fund:				
Operating	(20,000)	(20,000)	(20,000)	(20,000)
Legislative	(18,700)	(18,700)	(18,700)	(18,700)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE CONTRACTORS

Authorizing Legislation: Social Security Act, Sections 1816 and 1842, 42 U.S.C 1395.

Purpose and Method of Operations

The Medicare contractors perform the government's responsibility of reimbursing Medicare beneficiaries and providers of service in a timely, accurate, and fiscally responsible manner. Our growing aging population and their respective need for medical services, compounded by inflation in the cost of health care, causes outlays for Medicare benefits to spiral. In FY 1987, outlays for Medicare's 32.3 million beneficiaries will be approximately $82.3 billion with an estimated workload of 354 million claims. HCFA has and will continue to implement policies designed to control cost through changes in reimbursement methodology and aggressive efforts to detect fraud and abuse. The Medicare contractors are at the core of this dynamic environment and play a vital role in the processing of Medicare claims and preserving the fiscal integrity of the trust funds.

The cost of administering the Medicare program will be $1,056.1 million in FY 1987 - 1.3 percent of total Medicare outlays. HCFA has successfully reduced the proportionate share of administrative costs while, at the same time, it has imposed greater demands on the Medicare contractors. These additional responsibilities resulted from changes in Medicare reimbursement policy, initiatives to reduce program expenditures, enhanced HCFA focus on new priorities, and an increase in claims workload.

Intermediaries are responsible for reimbursement to providers of services under Part A of the Medicare program. These responsibilities encompass receiving and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayments, and safeguarding trust funds against payment for services that are not medically necessary. Significant changes have been made to the reimbursement methodology for inpatient hospital services. Under HCFA's Prospective Payment System (PPS) intermediaries reimburse hospitals for inpatient services based upon the number of Medicare beneficiaries in a Diagnosis Related Group (DRG) and the DRG rate for the primary diagnosis. The PPS replaces the cost per case limits created by the Tax Equity and Fiscal Responsibility Act (TEFRA). However, hospitals in those States which are exempt from PPS will continue to be reimbursed according to the provisions of the waiver.

Carriers are responsible for reimbursement to beneficiaries and providers of service under Part B of the Medicare Program. These responsibilities include receiving and accounting for Medicare benefit payments, accounting for funds made directly to and/or on behalf of eligible Medicare beneficiaries, determining the allowable reasonable charge for a covered service that was medically necessary, computing and recovering overpayments if reimbursement was made erroneously, and establishing methodologies to identify aberrant utilization patterns which deviate from medically accepted norms and bringing such patterns to the attention of the appropriate professional groups.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

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The Medicare contractors perform the government's responsibility of reimbursing Medicare beneficiaries and providers of service in a timely, accurate, and fiscally responsible manner. Our growing aging population and their respective need for medical services, compounded by inflation in the cost of health care, cause outlays for Medicare benefits to spiral. In FY 1987, outlays for Medicare's 32.3 million beneficiaries will be approximately $82.3 billion with an estimated workload of 336 million claims. HCFA has and will continue to implement policies designed to control cost through changes in reimbursement methodologies and aggressive efforts to detect fraud and abuse. The Medicare contractors are at the core of this dynamic environment, and play a vital role in the processing of Medicare claims and preserving the fiscal integrity of the trust funds.

The cost of administering the Medicare program will be $1,096.1 million in FY 1987 -- 1.3 percent of total Medicare outlays. HCFA has successfully reduced the proportionate share of administrative costs while, at the same time, it has imposed greater demands on the Medicare contractors. These additional responsibilities resulted from changes in Medicare reimbursement policy, initiatives to reduce program expenditures, enhanced HCFA focus on new priorities, and an increase in claims workload.

Intermediaries are responsible for reimbursement to providers of services under Part A of the Medicare program. These responsibilities encompass receiving and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayments, and safeguarding trust funds against payment for services that are not medically necessary. Significant changes have been made to the reimbursement methodology for inpatient hospital services. Under HCFA's Prospective Payment System (PPS) intermediaries reimburse hospitals for inpatient services based upon the number of Medicare beneficiaries in a Diagnosis Related Group (DRG) and the DRG rate for the primary diagnosis. The PPS replaces the cost per case limits created by the Tax Equity and Fiscal Responsibility Act (TEFRA). However, hospitals in those States which are exempt from PPS will continue to be reimbursed according to the provisions of the waiver.

Carriers are responsible for reimbursement to beneficiaries and providers of services under Part B of the Medicare Program. These responsibilities include receiving and accounting for Medicare benefit payments, accounting for funds made directly to and/or on behalf of eligible Medicare beneficiaries, determining the allowable reasonable charge for a covered service that was medically necessary, computing and recovering overpayments if reimbursement was made erroneously and establishing methodologies to identify aberrant utilization patterns which deviate from medically accepted norms and bringing such patterns to the attention of the appropriate professional groups.

Intermediaries and carriers provide information, guidance and technical support to both providers of service and beneficiaries on the administration of the Medicare program. Costs incurred by the intermediaries of $349.7 million and carriers of $667.7 million in fulfilling their respective responsibilities are reflected in the Medicare contractor budget request.

HCFA currently negotiates 93 contracts with intermediaries and carriers, including five (5) experimental fixed price contracts. HCFA is responsible for monitoring all of these contractors' expenditures, tracking savings realized from payment safeguard activities and productivity investments, and reviewing contractor performance in paying claims, serving Medicare beneficiaries and assuring the fiscal integrity of the Medicare trust funds.

HIGHLIGHTS

Program Initiatives Workgroup (PIW) Activities - PIW represents a management effort to develop program initiatives to reduce the losses to the Medicare trust funds by expanding payment safeguard activities. This will be accomplished by employing vigorous efforts to assure ourselves that reimbursement is made for only covered services rendered to eligible beneficiaries for an amount within reasonable cost or charge limits. In addition, PIW is expected to create an environment that reduces the likelihood of new sources of losses to the trust funds.

Secondary Payer - In FY 1985, HCFA worked with and issued instructions to the contractors on identifying base Medicare beneficiaries covered by other insurance. Our purpose was to make the private insuror the primary payer of claims and assure ourselves that Medicare pays only for these services not covered by private insurance. This activity, Medicare Secondary Payer (MSP) will continue in FY 1986 and FY 1987.

Standard System - Due to the ongoing changes to the Medicare program, the contractors are constantly making systems changes to comply with new programmatic requirements. The goal is to convert 30 intermediaries and 3 carriers to efficient transportable systems in FY 1987. In addition, HCFA is planning processing consortiums to develop State-of-the-art model claims processing specifications.

Reducing Scope of Audits

Funding levels applied to the audit of hospital cost reports reflect a significant decrease in the total number of audits to be performed, as well as a significant reduction in the amount of resources (audit hours) to be expended on each audit. Consequently, the audit budget is reduced as the result of our auditing approximately 500 fewer hospitals in FY 1987 than were audited in FY 1986, and by limiting our scope of audit to about 60 percent of that of the base period effort. Further reductions in the FY 1987 audit budget result from the elimination of all backlogged cost reports during FY 1986, and the provision of more defined audit criteria for HHA and SNFs.

Pacemaker - DEFRA Section 2304 requires HCFA to work with the Commissioner of the Food and Drug Administration to provide for a registry of all cardiac pacemaker devices and pacemaker leads. HCFA has required providers to track warranties on pacemakers beginning in FY 1985. This activity will allow Medicare to recover the costs of malfunctioning devices and limit the number of problem devices on the market.

Contingency Funds

HCFA has historically requested contingency fund monies for unanticipated workload increases which could not be otherwise absorbed. However, this year HCFA is requesting a legislative contingency in addition to the operating contingency to fund proposed law items which cannot be absorbed elsewhere in our request. These items include activities related to Home Health Agency, Working Aged, and extension of the Physician Fee Freeze.

MEDICARE CONTRACTOR BUDGET
FY 1987
(Dollars in Millions)

	FY 1985 Estimate	FY 1986 Request	FY 1987 Request	Program Dollar Savings
PAYMENT SAFEGUARDS				
Medical Review/Utilization	$ 72.5	$ 90.9	$ 104.8	$ 714.8
Audit	99.0	90.9	86.0	430.0
Medicare Secondary Payer	19.0	28.0	28.1	887.0
Total Payment Safeguards	$190.5	$209.8	$ 218.9	$ 2,031.8
PRODUCTIVITY INVESTMENTS	$ 40.0	$ 21.6	$ 27.6	
CLAIMS PROCESSING				
Bill/Claims Payment	$501.0	$498.9	$ 555.6	$ 8,113.6
Reimbursement	21.3	22.3	24.7	
Printing	4.0	3.1	3.1	
Fixed Price Contracts	49.3	53.4	62.0	
Total Claims Processing	$575.6	$577.7	$ 645.4	$ 8,113.6
BENEFICIARY & PROVIDER SERVICES				
Hearings	$ 28.7	$ 25.9	$ 26.5	
Eliminate Waiver Presumption	0.0	16.4	17.8	
Beneficiary Communications	62.8	53.4	63.8	
Participating Physicians	15.0 1/	15.2	17.4	
Total Beneficiary & Provider Services	$106.5	$110.9	$ 125.5	
Total Operating Funds	$912.6	$920.0	$1,017.4	$10,145.4
Contingency Fund - Operating	20.0		20.0	
- Legislative	0.0	15.0	18.7 2/	
Total Contractor Budget	$932.6	$935.0	$1,056.1	$10,145.4

1/ These funds were provided by the Deficit Reduction Act of 1984 (P.L. 98-369) for the implementation of the physician fee freeze and the participating physician program.

2/ These funds are requested for the following proposed legislative items - Home Health Agency, Working Aged and the Extension of the Physician Fee Freeze.

Rationale for the Budget Request:

I. PAYMENT SAFEGUARDS

In addition to the processing and payment of claims from providers of service and Medicare beneficiaries, a priority of HCFA is for the contractors to perform a medical review of claims to ascertain whether the services were medically necessary and constituted an appropriate level of care, to audit the Medicare cost reports of providers, and to assure that Medicare is the secondary payer if a beneficiary's services are covered by private insurance (MSP). These medical review, audit and MSP activities are referred to as payment safeguards.

A. Intermediary Medical Review

HCFA implemented the Peer Review Organization (PRO) program by awarding contracts in 54 PRO areas, completing contracting activities during the 1st quarter FY 1985. Thus, PROs have responsibility for the review of all inpatient hospital services. Intermediaries have retained responsibility for review of services delivered in other than inpatient acute care settings, to assure that such services are medically necessary and appropriate.

During FY 1986, intermediaries concentrated most of their medical review resources on the review of hospital-based outpatient claims and on services provided by Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs). With the advent of PPS and the increasing number of home health providers, it was deemed necessary to closely monitor claims for both of these services so as to deter abuse through early discharges by hospitals and to institute immediate and appropriate remedial actions if abuse was detected.

In FY 1987, intermediaries will refine review methods so as to target and more closely identify areas for more intensive review. Emphasis will continue to be placed on hospital-based outpatient services such as physical therapy. Emphasis on home health agencies will focus on utilization through use of a standard medical information form and revised home health screens. Home health review changes effected during FY 1986 are expected to provide for uniformity of benefits and to assure that services provided are medically necessary. Required review methodologies of home health and hospice claims will continue to incorporate home visits. Intensive review will be required for claims from comprehensive outpatient rehabilitation facilities (CORFs).

Instructions were issued to fiscal intermediaries during FY 1985 to identify medical review costs associated with claims processing and to transfer such costs to the medical review activity. To the extent such shifts in costs are accomplished, comparable adjustments of resource availability will be required between these activities in FY 1986 and FY 1987.

Intermediary medical review costs will increase from $32.2 million in FY 1986 to $36.5 million in FY 1987. This increase is primarily attributable to workload growth and inflationary increases which are consistent with the latest EOMB economic indicators. Savings in FY 1987 are expected to be $182.5 million.

B. Carrier Medical Review

Part B medical review consists of a two-tiered approach to identify inappropriate services and take action when questionable patterns of practice are found. One approach is the development and use of more sharply defined computerized prepayment utilization screens to control inappropriate claims and overutilization. Carriers now have in place numerous screens based upon previously identified problem areas. Several mandated screens with parameters will be instituted nationwide during FY 1986. These screens assure uniformity of application toward areas of national concern and provide contractors with the capability to examine these claims for services which are adjudged to be subject to abuse; to take corrective action where needed, and impose controls on payment for services rendered by problem providers before a claim is fully processed. Review protocols have been developed by HCFA and carrier personnel are required to use these protocols in their review of claims that fail the screens.

When a claim fails a prepayment screen, it must be reviewed by the carrier. The first level of such review is normally performed by clerical personnel or claims examiners with the aid of written guidelines. Questions which cannot be resolved at this level are referred to a second level of review, traditionally performed by paramedical personnel or registered nurses. These reviewers obtain additional information and undertake appropriate development of claims in order to make a decision on the medical necessity of services rendered. The third, and final, level of review is performed by physicians who are either employed by the contractor or available on a consultant basis.

The second tier of medical review is the use of postpayment reviews. The postpayment review process assists in the identification of potentially fraudulent or abusive practices requiring more intensive investigation and followup through:

1. monitoring physician, supplier or laboratory claims through use of experience and development of appropriate statistical data;

2. identification of physicians, suppliers and laboratories with aberrant utilization patterns; and

3. recovery of overpayments.

Another source for detecting inappropriate payments results from the review of data pertaining to such Part A denials as inpatient and SNF services. This data is provided to carriers monthly by fiscal intermediaries on computer tapes. Claims for physicians' services associated with medical denials must be reviewed intensely since there is a strong likelihood that the associated physician services are also not medically necessary.

In addition, postpayment review identifies the need for new or modified prepayment controls. For example, prepayment screens are developed on the basis of postpayment review findings, thereby enabling contractors to examine questionable or potentially abusive procedures before payment is made. Further, carriers perform Program Integrity activities and provide support to the HHS/OIG to identify and develop cases of fraud or abuse.

In FY 1987, HCFA intends to continue directing carriers to expand and intensify their present review efforts to reduce the potential for inappropriate cost shifting under the PPS and to achieve a maximum program savings return ratio. Carrier medical review costs will increase from $58.7 million in FY 1986 to $67.9 million in FY 1987. This increase is primarily attributable to workload growth and inflationary increases which are consistent with the latest EOMB economic indicators. These costs are offset by substantial savings to the Medicare program. HCFA anticipates $532.3 million in savings during FY 1987.

Medical Review FY 1987

Fiscal Intermediaries

PART A	BILLS	PERCENT COVERAGE	NUMBER OF REVIEWS	UNIT COST	TOTAL COST
Inpatient	12,421,140	0	0	0	0
Outpatient	38,505,535	8.6	3,299,083	$5.44	$17,947,014
HHA	6,831,627	47.0	3,210,865	$5.44	17,467,106
Compliance reviews			3,000	$1,000.00	3,000,000
SNF	1,242,114	45.0	558,951	$5.44	3,040,693
Other (includes CORF, Hospice)	3,105,285	5.0	155,264	$5.44	844,636
	62,105,701		7,227,163		$42,299,449
(Less Fixed Price)	(8,577,536)				(5,841,988)
TOTAL	53,528,165				$36,457,461

Medical Review FY 1987

Carriers

PART B	CLAIMS	PERCENT COVERAGE	NUMBER OF REVIEWS	UNIT COST	TOTAL COST
Prepay	318,230,000	15.0	47,734,500	$1.09	$52,030,605
Postpay					19,889,375
TOTAL	318,230,000				$71,919,980
(Less Fixed Price)	(17,775,384)				(4,017,236)
TOTAL	300,454,616				$67,902,744

C. Audit of Provider Cost Reports

In FY 1987, the audit of provider cost reports will continue as a major program safeguard initiative. Program payments for beneficiary services are anticipated to approach $70 billion by FY 1987, and the audit of provider cost reports is the primary instrument with which the integrity of these funds is maintained. Historically, the audit process has recovered millions of dollars in improper program payments each year. In FY 1983 and FY 1984 (base period audit effort for the Medicare prospective payment system (PPS)) provider audit recovered program payments in excess of $700 million and $1 billion, respectively. Early indicators also show that similar, significant program recoveries will result from provider audit through FY 1987. With the advent of the Medicare PPS, it is anticipated that there will be a decrease in the ratio of program recoveries to the cost of performing provider audits; however, this decrease may not be significant in terms of total program funds recovered since PPS has caused changes in the health industry (i.e., growth patterns in home health and skilled nursing care, and transitions in hospitals to open distinct part units that are exempt from PPS) which lend themselves to audit and program recoveries.

In addition to growth patterns and transitions in the health care industry, there are other program considerations addressed in the FY 1987 audit plan. The percentage of PPS hospitals to be audited (audit level) remains relatively high since there has been a great deal of speculation that the diagnostic related group (DRG) payment rates will need to be rebased, or at least studied for the purpose of a possible rebasing. Also, legislative proposals are being developed to incorporate capital-related costs into prospective rates, which requires that accurate provider cost data be available.

The Administration has been confronted with two major policy issues which may have a material effect on both the FY 1986 and FY 1987 audit workplans. These issues pertain to reimbursement for malpractice costs and the inclusion of labor/delivery room days in the calculation of per diem costs.

Presently, the Administration is proposing to modify Medicare payment policy for malpractice insurance costs. The proposed methodology for implementing this change would require, at a minimum, the revision of thousands of Medicare provider cost reports at an estimated cost of $3.6 million. This issue could have a considerably greater effect on audit costs depending upon the final malpractice reimbursement methodology. Therefore, it is likely that FY 1986 audit resources, to some extent, would be diverted away from audit, creating a backlog to be audited in FY 1987.

The second issue (labor/delivery room days) stems from recent court decisions which state that labor/delivery room days should not be included when calculating hospital per diem costs. Accordingly, it may be necessary for all intermediaries to reopen their settled hospital cost reports for all years eligible for reopening, and recalculate the Medicare reimbursable cost. Information is not currently available to allow for an estimate of the potential costs associated with this issue.

(The attached FY 1986 and 1987 audit plans do not reflect the potential effect of these issues.)

Based on program statistics for the 5-month period beginning October 1, 1984, there are 797 new HHAs and 381 new SNFs participating in the Medicare program, representing increases of 18.12 percent and 6.24 percent, respectively. Considering this trend will remain relatively constant throughout FY 1986, we anticipate that there will be approximately 1300 additional new providers (HHAs and SNFs) subject to audit under cost-based principles of reimbursement in FY 1987.

The data also shows that there has been a decrease (6.53 percent) in the number of hospitals under PPS that are single entity providers, and an extremely sharp increase (19.62 percent) in the number of PPS hospitals with excluded units and other subproviders which are exempt from PPS. Also, there has been an additional increase (8.65 percent) in the number of hospitals participating in the Medicare program that are exempt from PPS which is represented by 123 new hospitals having entered the program.

Approximately 93 percent of total program payments are paid to hospitals. Our review of these hospital payments indicates that amounts paid to non-PPS providers, in addition to the cost portion of payments to PPS providers, represents 39 percent of total payments to providers. Therefore, in addition to auditing providers which are on a cost basis, it will still be necessary to perform a considerable amount of audit effort (60 percent of a full scope audit effort) on PPS providers in order to verify the amount reimbursed on a cost basis, in addition to responding to the special policy issues discussed earlier.

The audit of hospital cost reports shows that intermediaries are recovering approximately $5 in improper program payments for every dollar spent on audit. These are cost reports filed under the Tax Equity and Fiscal Responsibility Act (TEFRA) regulations and are reimbursed based upon cost. The audit of PPS cost reports will be directed through the issuance of revised PPS audit guidelines, to the verification of the core data, as well as to the verification of Medicare's proportionate share of pass-through items (i.e., capital, indirect and direct medical education costs and outlier costs) and the allocation of costs between hospital inpatient and outpatient departments. Since outpatient services and distinct part units continue to be reimbursed based upon reasonable costs, there is a potential for cost shifting to maximize Medicare reimbursement.

Based upon our review of the base period audit findings, we identified the most significant and recurring audit adjustments, and designed audit strategies to identify the existence of each issue. There were 30 significant issues identified and they were applied for the first time during the audits of the first hospital cost reports filed under TEFRA regulations. These guidelines, in concert with the guidelines developed specifically for PPS, will be applied during FY 1986 and FY 1987.

Many of the 30 adjustments previously identified may only reduce program reimbursement to PPS hospitals by 4 percent of the amount adjusted, considering that PPS hospital inpatient costs are reimbursed based upon DRG rates, and are not affected by cost adjustments. However, five of the eight most significant adjustment areas relate to pass-through costs which under PPS continue to be reimbursed on a cost basis.

Adjustments to capital-related costs, i.e., depreciation, interest and equity capital, could affect Medicare program reimbursement by an estimated $310 million. Other adjustment areas which include improper cost shifting to cost based areas, related organization costs, and nonallowable cost centers may result in an additional $74 million in reductions to program costs. (Amounts discussed in this paragraph were projected for the FY 1986 audit effort.)

The audit of PPS and non-PPS (TEFRA) hospital cost reports will be arrayed and prioritized based upon the Audit Priority Matrix and related audit budget guidelines. Hospitals which are both multi-facility complexes (existence of subproviders) and part of a chain will be the top priority. The existence of either of these conditions will also indicate high audit priority.

There are over 3000 hospital providers which meet these criteria. The reason we have placed emphasis on these providers is that they encompass the audit of at least one added subprovider, i.e, skilled nursing facility, home health agency, related organization; thus, resulting in the audit and settlement of at least two cost reports.

The remaining hospitals will be prioritized and selected for audit depending upon the presence of the following conditions:

- Existence of PPS excluded units (i.e., psychiatric and rehabilitation units)
- Pass-through costs
- Outpatient costs
- Approved teaching program

Each of these conditions relate to a provider's cost-based reimbursement, which the intermediary will assess in determining the need for audit.

We have determined that most hospital audits will still require 60 percent of the audit effort expended on the base period cost reports, even though the portion of a PPS hospital's Medicare reimbursement which is based on cost may only be 15 - 20 percent. Therefore, the number of audit hours per PPS hospital has been reduced to 60 percent of the level applied in the base year. The reduction in the scope of audit was initiated in FY 1986 and will be carried through FY 1987.

Beginning in FY 1984, intermediaries initiated audits of the hospital cost reports for those providers located in PPS waiver States (New Jersey, Massachusetts, New York and Maryland). These audits will continue on an ongoing basis in FY 1986 and FY 1987 at the same audit level as PPS and TEFRA cost reports. Accordingly, the audit hours required to complete each audit should be approximately 60 percent of the previous effort.

There is a potential backlog of provider cost reports that may be present in FY 1987 as explained earlier, because of the malpractice and labor room issues. However, we cannot estimate the potential backlog at this time because of the uncertainty of the disposition of these issues.

Based upon the TEFRA provisions and the implementation of PPS, there are numerous incentives for chain home offices to maximize the amount of capital costs allocated to hospitals, and to allocate as much operating cost as possible to providers that remain on a cost reimbursement basis, i.e., HHAs and SNFs. Therefore, we will focus our audit efforts on costs reported and allocated by home offices. In addition, we will be reviewing all significant mergers and acquisitions to determine the effect on Medicare reimbursement. This activity will be coordinated through our Special Mergers and Acquisitions Review Team (SMART).

As a result of PPS, we have identified that Medicare utilization and reimbursement to other types of providers, particularly HHAs, has significantly increased. Statistics for the 6-month period ending March 31, 1985, show that Medicare payments to HHAs have increased 21 percent. Of the Medicare-certified HHAs, approximately 34 percent receive 85 percent of the Medicare reimbursement. Approximately 9 percent of the Medicare-certified SNFs receive 43 percent of the program reimbursement. By auditing cost reports of 34 percent of the HHAs and 9 percent of the SNFs, we will be reviewing approximately $1.2 billion in benefit payments.

There are other types of providers which receive reimbursement under the Medicare program. These providers include, but are not limited to, hospices, end stage renal disease (ESRD) facilities, rural health clinics, and health maintenance organizations (HMOs). These providers must be audited to varying degrees every year. Hospices must be reviewed in order to fulfill our commitment to Congress to apprise them of hospice operating costs; ESRDs must be audited at least from an exception prospective, and the new emphasis on HMOs and their rapid growth also requires an extensive audit effort.

As intermediaries redirect their audit activity to focus on certain types of cost and provider types other than hospitals in FY 1985 and FY 1986, HCFA will analyze the audit findings to determine the relative payback of auditing various classes of providers. The results of the analysis will be used to project future audit levels as well as to allocate audit resources to areas which prove to be most productive.

There is a potential backlog of provider cost reports that may be present in FY 1987 as explained earlier, because of the [illegible] and [illegible] issues. However, we cannot estimate the potential backlog at this time because of the uncertainty of the [illegible] of these issues.

Based upon the TEFRA provisions and the implementation of PPS, there are numerous incentives for [illegible] to maximize the amount of capital cost reimbursed to hospitals, and [illegible] allocations that [illegible] operating cost as possible to providers that remain on a cost basis, such as [illegible], HHAs and SNFs. Therefore, we will [illegible] with [illegible] to [illegible] and [illegible] these [illegible]. [illegible] will be reviewing all significant [illegible] and [illegible] in [illegible] the [illegible] of Medicare reimbursement. This activity will be [illegible] through our Special Analysis and Resolution [illegible] (SARP).

As a result of PPS, we have identified that Medicare utilization and reimbursement [illegible] to other types of providers, particularly HHAs, has significantly increased. Statistics for the 6-month period ending March 31, 1987, show that Medicare payments to HHAs have increased 25 percent. Of the Medicare-certified HHAs, approximately [illegible] percent received [illegible] percent of the Medicare reimbursement. Approximately 7 percent of the Medicare-certified SNFs received 35 percent of the program reimbursement. By [illegible] of the HHAs and 7 percent of the SNFs, we will be reviewing approximately $1.2 billion in benefit payments.

There are other types of providers which receive reimbursement under the Medicare program. These providers include, but are not limited to, hospices, end stage renal disease (ESRD) facilities, rural health clinics, and health maintenance organizations (HMOs). These providers must be audited to varying degrees each year. We also must be prepared in order to fulfill our commitment to Congress to update [illegible] operating costs. ESRD [illegible] be audited at least [illegible], and the new emphasis on HMOs and their rapid growth also requires an extensive audit effort.

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FY 1987 AUDIT EFFORT BY TYPE OF PROVIDER

Hospitals		Percent to be Audited	Number to be Audited
PPS			
Total hospitals	5,313		
Multi-facility and part of chain	416	100%	416
	4,897		
Other multi-facility hospitals	1,152	80%	921
	3,745		
Other chain affiliated hospitals	1,042	70%	729
Remaining PPS hospitals	2,703	55%	1,486
Total PPS hospitals to be audited			3,552
Non-PPS Hospitals			
Total hospitals	1,608		
Chain affiliated	448	70%	314
	1,160		
Waiver State hospitals	573	70%	401
Remaining non-PPS hospitals	587	50%	293
			1,008
Total Hospitals to be Audited			4,560
Home Office Cost Reports			
Total number of chains	550		
Chains with over 10 providers	93	100%	93
	457		
Governmentals	32	20%	6
	425		
Proprietary	280	90%	252
Non-proprietary	145	75%	109
Total home office audits			460
Hospices			
Approximate FY 86 certified hospices	200	55%	110
HHAs			
Freestanding	5,556	34%	1,889
SNFs			
Freestanding	5,960	9%	536
Other			
ESRD, RHC, HMO and CORF	1,856	14%	259

(THIS SCHEDULE DOES NOT REFLECT THE CONTINGENT EFFECT OF THE PROPOSED MALPRACTICE INSURANCE ISSUE OR THE LABOR/DELIVERY ROOM ISSUE.)

FY 1987
AUDIT COST BY
TYPE OF PROVIDER
($ in millions)

	Number of Facilities	Audit Cost	Total Audit Cost	Percent of Benefits Audited
Desk Review	19,100	-	$ 19.1	
Field Audit:				
PPS Hospitals				
Multi-facility and part of chain	416	$4.4		
Other multi-facility hospitals	921	9.1		85%
Other chain affiliated hospitals	729	6.8		
Remaining PPS hospitals	1,486	12.3		59%
Total	3,552	32.6	32.6	
Non-PPS Hospitals				
Chain affiliated	314	3.1		
Waiver audits	401	3.6		
Remaining PPS hospitals	293	2.7		
Total	1,008	9.4	9.4	63%
Skilled Nursing Facilities				
Freestanding	536	1.1	1.1	43%
Hospital-Based	945	*		
HHAs				
Freestanding	1,889	3.8	3.8	75%
Hospital-Based	1,299	*		
Home Office				
Chain home office cost reports	460	4.7	4.7	
Other Audits				
Hospices	110	.3		
ESRD, RHC, HMO	259	.8		
	369	1.1	1.1	14%
Total Field Audit Cost			$ 52.7	74%
Cost Report Settlement:				
Normal Costs	19,100		13.4	
Settlement Backlog	1,100		.8	
Total Settlement Costs			$ 14.2	
Total Audit Cost			$ 86.0	

* Hospital-based SNFs and HHAs are included in multi-facility hospitals audit cost.

(THIS SCHEDULE DOES NOT REFLECT THE CONTINGENT EFFECT OF THE PROPOSED MALPRACTICE INSURANCE ISSUE OR THE LABOR/DELIVERY ROOM ISSUE.)

D. Medicare Secondary Payer

In FY 1984 and FY 1985, HCFA has worked with and issued instructions to the contractors on identifying base Medicare beneficiaries covered by other insurance. Our purpose was to make the private insuror the primary payer of claims and assure ourselves that Medicare pays ony for those services not covered by private insurance. This activity, Medicare Secondary Payer (MSP), has 5 distinct parts:

- Working Aged Insurance
- Spousal Working Aged Insurance
- Automobile, Medical, Liability and No-Fault Insurance
- End Stage Renal Disease (ESRD)
- Workers' Compensation

Estimated MSP savings to the Medicare trust funds are $702 million for FY 1986 and $887 million in FY 1987. During the first six months of FY 1985, $9 million was spent and $260 million in benefit savings were realized, a savings ratio of 29:1.

The primary objective of HCFA to have the providers of service, rather than the contractors, ascertain whether a Medicare beneficiary has other insurance and, if so, bill the primary insuror. We are also establishing edits to facilitate the identification of cases where Medicare may be the secondary payer. As part of our efforts to have the providers identify MSP cases, we have:

- developed a videotape training package for hospital admission and billing personnel. One videotape will be supplied to each regional office and intermediary during the last quarter of FY 1985.

- prepared a letter of Medicare beneficiaries advising them of the working aged provision and requesting that they identify other insurance coverage to their providers of service.

- required intermediaries to audit the MSP activities of one hospital per quarter or four a year.

- required contractors to conduct training on MSP for the providers they serve.

Funding for MSP in FY 1985 was originally $19 million. However, this was not sufficient for the contractors to develop and fully implement MSP and we received an additional $8 million from the contingency fund, for a total of $27 million. In FY 1986 and FY 1987, the contractors will need funds for system enhancements. Moreover, those contractors with MSP operations will need to automate and thus increase their efficiency. They will also need funds to develop, follow-up, and process MSP claims. A funding level of $28.1 million is requested for this effort in FY 1987. Associated benefit savings are estimated to be $887 million.

II. PRODUCTIVITY INVESTMENTS

Productivity investments are activities designed to make Medicare contractors' operations more efficient and cost effective. As a general rule when HCFA invests in the project, there must be corresponding savings in a contractor's claims processing costs. This would not apply where HCFA is requiring a systems change for program purposes.

Stringent return on investment criteria are used to assess whether new systems should be funded. At the time a contractor requests approval of a new claims processing system, documentation of the level of savings in claims processing costs that will be realized if the project is approved must be furnished. The contractor is, in fact, given a loan to fund the system. The funds must be repaid with interest (in terms of savings in claims processing costs) over a 2 year period. If the contractor demonstrates that the "loan" can be repaid within 2 years, the new system will be approved. Otherwise, funding will be denied.

Those investments funded in prior years generated significant savings in claims processing costs. In FY 1985 and FY 1986, each contractor was assigned a performance level unit cost. When arriving at the performance level unit cost, expected savings from productivity investments were factored into the calculation. These savings were part of the basis for estimating FY 1987 claims processing costs. Consequently, the chart below reflects savings in FY 1987 based upon investing the funds in FY 1987 as well as savings realized in FY 1985 and FY 1986.

Other initiatives represent activities which do not produce direct administrative savings, but are necessary to improve the overall quality and effectiveness of administering the Medicare program. Some of these initiatives are mandated by statute.

A description of each proposed initiative follows:

Electronic Media Claims (Part A and Part B ($4.5 Million)

The Electronic Media Claims (EMC) initiative represents an effort to convert Part A bills and Part B claims to electronic media submission. The resultant elimination of data entry costs generates significant savings. In FY 1987, we believe 61 percent of the Part A bills will be submitted electronically, an increase of 12 percent over FY 1985. Our goal is to take advantage of prior years' marketing efforts at hard sell providers. Intermediaries will need funds for increased line capacity as well as upgraded equipment. The estimated cost of this effort is $1.0 million in FY 1987; savings are estimated to be $1.0 million. While the savings is equal to the cost in FY 1987, the savings from this effort continue in future years. We also believe 30 percent of the Part B claims will be submitted electronically in FY 1987, an increase of 10 percent over FY 1985. We plan to take advantage of prior years' marketing efforts at small volume providers. Carriers will need funds for increased line capacity and upgraded equipment to enhance their capability to receive different types of claims electronically. The estimated cost of this effort is $3.5 million in FY 1987; savings are estimated to be $5.3 million. These savings as in Part A continue in future years.

Standard System (Part A and Part B) ($12.5 Million)

Due to the ongoing changes to the Medicare program, the contractors are constantly making systems changes to comply with new programmatic requirements. In FY 1987, we plan to convert 30 intermediaries to efficient transportable systems. We will implement a transportable system for carriers at 3 test sites in FY 1987. Further implementation will take place in FY 1988. We are also planning processing consortiums and to develop State-of-the-art standard claims processing specifications. This will facilitate the implementation of required programming changes as well as enable us to readily transfer workload from high cost, poor performing contractors.

Contractors will need funds in FY 1987 to design as well as write, test, and debug computer programs. They will also need to install the system, train staff, test the system and run it parallel with their old system until they are certain the new system is operational.

Savings will begin to accrue in FY 1988. With a standard system when changes are required (such as the physician fee freeze or PPS), one contractor will be funded for the changes and others will install it. By paying only one contractor to make the changes, significant dollars will be saved. We are requesting $12.5 million for this effort in FY 1987.

Upgrade of Claims Processing Systems (Part A and Part B) ($3.0 Million)

Systems upgrades represent the cost of contractors upgrading their systems to comply with legislative/programmatic changes. We estimate 5 intermediaries and 1 carrier will be upgrading their systems to comply with required changes in FY 1987. Savings will be realized because we are paying a small number of contractors to make changes that will apply to all; thus, other contractors will not incur these same costs. We request $3.0 million for this effort in FY 1987; savings of $1.5 million will be realized as a result.

Contractor Reconfiguration ($.8 Million)

Section 2326(b) of the Deficit Reduction Act requires that the number of designated regional intermediaries serving freestanding home health agencies be reduced to no more than 10 by July 1, 1987. HCFA intends to take this one step further and transfer provider-based home health agencies to the regional intermediaries in FY 1987. This will enable us to better manage home health benefits since 10 intermediaries will process all home health bills, not only those from freestanding facilities. We are requesting $0.8 million to complete this transfer in FY 1987.

Contractor Strategy ($2.7 Million)

For FY 1987, Section 2326(a) of DEFRA gives the Secretary of Health and Human Services the authority to enter into no more than two competitively bid contracts under Sections 1816 and 1842 of the Social Security Act. This section of law is interpreted by the Office of the General Counsel to be limited to cost contractors. We are limited to replacing an organization which over time has been in the lowest 20th percentile as measured by the Secretary's cost and performance criteria. Such competitions may disregard the nomination process, must be with health insuring organizations and must not split contractor functions.

In FY 1987, HCFA plans to enter into one Part A and one Part B competition. We plan to implement one contract in a single State and the other in multiple States. We are assuming that implementation costs will be held down by competition. Costs are based upon bids for the most recent transition. We are requesting $2.7 million for this effort in FY 1987.

Consolidations ($1.8 Million)

We believe that one consolidation will take place in FY 1987 due to contractors no longer participating in the Medicare program. We are requesting $1.8 million in FY 1987 for termination and transition costs associated with the consolidation.

Pacemaker Registry ($1.0 Million)

The Deficit Reduction Act requires the Secretary to provide a registry for all permanent pacemakers and leads for which payment is made under Medicare. In order to meet this requirement, intermediaries must collect, edit and furnish additional pacemaker related data to HCFA, quarterly. Funding will be required during FY 1987 to support this activity. The collected data is furnished to the Food and Drug Administration, who maintains the registry.

Systems Security ($1.3 Million)

Contractors are required by the Executive Office of Management and Budget (EOMB) to meet minimum standards for systems and data security to protect the confidentiality of beneficiary and provider records. The systems security requirement of the Privacy Act is set forth in OMB Circular A-71. Based on a risk analysis, contractors are expected to implement or update appropriate administrative, technical and physical safeguards to comply with EOMB requirements.

PRODUCTIVITY INVESTMENTS
INTERMEDIARIES
(IN MILLIONS)

Proposal	Amount Requested FY 1986	Amount Requested FY 1987	Savings FY 1987
Electronic Media Claims	$ 2.0	$ 1.0	$1.0
Standard System	0.0	8.5	0.0
Upgrade of Claims Processing Systems	0.3	2.5	1.2
Contractor Reconfiguration	1.0	0.8	0.0
Contracting Strategy	2.8	1.5	0.0
Consolidations	0.0	1.8	0.0
Pacemaker Registry	0.0	1.0	0.0
Systems Security	0.6	0.6	0.0
Notice of Admission Charges	1.7	0.0	0.0
Beneficiary Initiatives	0.2	0.0	0.0
Expansion of UB-82	0.8	0.0	0.0
Total Intermediaries	$ 9.4	$17.7	$2.2

PRODUCTIVITY INVESTMENTS
CARRIERS
(IN MILLIONS)

Proposal	Amount Requested FY 1986	Amount Requested FY 1987	Savings FY 1987
Electronic Media Claims	$ 4.0	$ 3.5	$ 5.3
Standard System	0.0	4.0	0.0
Upgrade of Claims Processing Systems	1.9	0.5	0.3
Contracting Strategy	1.2	1.2	0.0
Systems Security	0.7	0.7	0.0
Eliminate Query Process	2.5	0.0	0.0
Teaching Physicians	1.1	0.0	0.0
Beneficiary Initiatives	0.8	0.0	0.0
Total Carriers	$12.2	$ 9.9	$ 5.6
All Contractors	$21.6	$27.6	$ 7.8

III. CLAIMS PROCESSING

A. Claims Payment - $555.6

Contractors must determine whether services for which claims are received are covered, whether the patient is entitled to benefits, and the amount of payment in a timely and accurate manner.

Claims payment includes direct and indirect costs associated with the receipt, processing and payment of Medicare claims. These costs include labor, ADP and administrative support activities for cost-contractors only. Also included are the costs of processing claims for certain demonstration projects.

The following tables show workload and unit cost data for Fiscal Years 1984-1987.

(Workload in Millions)

Part A	FY 1984	FY 1985	FY 1986	FY 1987
Total Bills	49.1	57.2	59.6	62.1
%Change		16.5	4.2	4.2
Part B				
Total Claims	224.7	255.6	289.3	318.2
%Change		13.8	13.2	10.0

The Claims payment unit cost is derived by dividing the cost of this activity by the bill/claims workload. The table below indicates the trend in the cost of processing claims.

Unit Cost

Cost Contracts:	FY 1984	FY 1985	FY 1986	FY 1987
Part A	$ 2.64	$ 2.33	$ 1.93	$ 1.97
Part B	$ 2.04	$ 1.95	$ 1.74	$ 1.75

FACTORS IMPACTING WORKLOAD AND UNIT COST

- Workload is based upon FY 1985 estimated actual claims and has been adjusted by the actuary's rate of increase between FY 1985 and FY 1986 and FY 1986 and FY 1987 (4.2 percent for Part A; 10.0 percent for Part B) to the FY 1985 base.

- We are assuming that Part A workload is at budget for FY 1985 and that Part B will be 8 million over budget. This increased workload is our basis for estimating FY 1987. The workload pending will increase during FY 1985 and FY 1986 by these 8 million claims. However, in FY 1987 we will require sufficient funds to process all receipts.

- Inflation is assumed to be 4.2 percent which is consistent with the latest EOMB economic indicators.

- The unit cost is based upon the FY 1986 cost after reducing for savings from MARI and productivity investments and reducing all contractors to the top of the bottom quartile. The postage increase was then added to this amount; $0.01 for Part A and $0.02 for Part B.

- We are assuming that the FY 1987 incremental workload can be processed at 75 percent of the cost of the workload base. The productivity rate has not been changed from previous years even with the efficiencies achieved by the contractors in FY 1986. MARI initiatives will be used to enable the contractors to maintain the FY 1986 operating efficiencies in FY 1987. Examples of MARI initiatives include:

  - Allow contractors to issue a stop payment on benefit checks less than the $50 unless the cost of doing so would exceed the amount of the check.

  - Eliminate the return of hard copy drug bills and to announce an active campaign then effect certain date drug bills will not be returned.

  - Change PPS intermediary/carrier data exchanges from monthly to quarterly.

  - Do not make payment on initial claims of less than $1.00.

  - Change duplicate checking functional standard.

  - Reduce the number of onsite EMC verification reviews.

- Claims payment includes $15.4 million for other ongoing costs such as parenteral/enteral claims, the BCA contract, HMO audits, GAO/OIG special studies, and special projects.

- Claims payment has been decreased for savings from EMC and Systems Upgrades.

B. In addition to claims payment expenses, Medicare contractors incur other costs that are related to the processing of claims. Some of the costs are incurred only by intermediaries, some are incurred only by carriers and some are incurred by both.

- Costs Incurred by Intermediaries Only

  Reimbursement ($24.7 million) - Prospective Payment System (PPS), contractors must establish reimbursement rates based on reasonable cost as required by law and regulations. For PPS providers, contractors must pay the applicable DRG rates in determining the reasonable costs of pass through expenses such as capital investments and medical training. Contractors are also responsible for establishing Periodic Interim Payments, as applicable, identifying and recovering overpayments, and maintaining working relationships with providers. The number of providers has been increasing in this area at a rate of 6-7 percent, so the FY 1987 budget assumes a workload growth of 6-5 percent plus inflation. In FY 1987 the cost of these functions will increase by $2.4 million due to increased workloads and inflation.

- Eliminate Favorable Waiver of Liability Presumption ($17.8 million) - This function continues the activity related to the FY 1985 and FY 1986 implementation of the increased reconsideration costs resulting from the elimination of the favorable waiver of liability presumption for providers. Under these presumptions Medicare paid for services whenever a provider would be considered not to know, or have reason to know the certain services were not covered. To have the advantage of a favorable waiver of liability presumption a hospital or a home health agency (HHA) had to have an error rate (denial rates) of no more than 2.5 percent for hospitals and HHAs, and 5 percent for SNFs. The FY 1985 regulation proposal eliminates the denial rate criteria and establishes a case by case analysis of the circumstances in determining the providers eligibility for program payments. The FY 1987 increase in this cost of $1.4 million is related to workload growth and inflation.

- Costs Incurred by Carriers Only

  Beneficiary Communications $63.8 million) - The Medicare program is complex, based on many provisions required by law, regulations and policy dealing with entitlement, coverage of services and limitations on coverage, comprehensive payment rules, and the rights and responsibilities of beneficiaries. Since contractors are the direct link between beneficiaries and the program, this activity includes all costs related to beneficiary inquiries generated by means of telephone, correspondence, and walk-ins. The FY 1987 increment for this function is $10.5 million.

- Participating Physicians ($17.4 million) - Significant costs will be incurred for participating physicians whether or not the freeze is extended. Carriers will still be required to solicit participation agreements, provide EMC lines, continue to handle the additional

B. In addition to claims payment expenses, Medicare contractors incur other costs that are related to the processing of claims. Some of the costs are incurred only by intermediaries, some are incurred only by carriers and some are incurred by both.

o Costs Incurred by Intermediaries Only

Reimbursement ($98.2 million) - Prospective Payment System (PPS) contractors must establish reimbursement rates based on reasonable cost as required by law and regulations. For PPS providers, contractors must pay the applicable DRG rates in determining the reasonable costs of pass through expenses such as capital investments and medical training. Contractors are also responsible for establishing Periodic Interim Payments, as applicable, identifying and recovering overpayments, and negotiating working agreements with providers. The number of providers has been increasing in this area at a rate of 4.7 percent in the FY 1982-1985 period, reflects a workload growth of 4-5 percent and inflation. In FY 1986 the cost of these functions will increase by $2.4 million due to increased workloads and inflation.

o Providers Payments Reimbursement Liability Determination ($17.3 million) - This function continues the activity initiated in the FY 1985 and FY 1986 implementation of the increase in costs resulting from the elimination of the favorable waiver of liability presumption for providers. Under these provisions Medicare paid for services whenever a provider would be considered not to know or have reason to know the certain services were not covered. To have the advantage of a favorable waiver of liability presumption a hospital or a home health agency (HHA) had to have an error rate (denial rate) of no more than 2.5 percent for hospitals and HHAs, and 5 percent for SNFs. The FY 1985 regulation proposal eliminates the denial rate criteria and substitutes a case by case analysis of the circumstances in determining the providers eligibility for favorable payments. The FY 1986 increase in this cost of $1.4 million is related to workload growth and inflation.

o Costs Incurred by Carriers Only

Beneficiary Communications ($51.4 million) - The Medicare program is complex, based on many provisions required by law. Regulations and subject continually with entitlement, coverage of services and limitations on coverage, reimbursement payment rules, and the rights and responsibilities of beneficiaries. Since carriers are the primary link between beneficiaries and the program, this activity includes all costs related to beneficiary inquiries generated by means of telephone, correspondence, and walk-ins. The FY 1986 increment for this function is $10.5 million.

o Participating Physicians ($15.0 million) - Significant costs will be incurred for participating physicians whether or not the freeze is extended. Carriers will still be required to solicit participation agreements, provide toll lines, continue to handle the additional inquiries, publish a directory of participating and non-participating physicians and publish a physician assignment rate list regardless of whether any additional program changes are made. The FY 1987 $2.2 million increase represents workload and inflation.

- Costs Incurred by All Contractors

  Hearings and Reconsiderations ($26.5 million) - This function includes all activities related to due process as a result of contractor disallowances of bills or claims. Beneficiaries, providers, and physicians are entitled under the law to request reconsiderations or formal reviews and hearings if they are dissatisfied with initial payment determinations made by contractors. Associated costs include all activities related to formalized hearings and appeals such as legal fees, recording fees, travel, and other incidental charges. The FY 1987 increment for this activity is $0.6 million. The increase is a result of increased workloads and inflation.

  Printing ($3.1 million) - In the interest of maintaining standard formats and quality of Medicare billing and report forms, HCFA supplies the forms used by beneficiaries and providers to file claims with Medicare Contractors. The use of these forms is essential to effective and efficient Contractor operations and other program purposes.

C. Experimental Fixed Price Contracts

Section 222 of Public Law 92-603 gives HCFA the authority to experiment with reimbursement to Medicare contractors for services rendered on other than a cost basis. The experimental contracts currently in force are in the fixed-price category. These contracts are awarded for a specific period of time and the total price changes only in terms of contract modifications. HCFA plans to enter into three additional experiments in the period from FY 1986 through FY 1987. These experiments will test the market place in terms of price and efficiency.

IV. CONTINGENCY FUNDS

- A contingency fund is normally requested to permit funding for workload or operating costs not anticipated at the time the budget is formulated. Examples of such costs are those needed to meet greater than budgeted workload increases, unanticipated increase in the rate of inflation growth, legislative requirements and unanticipated changes. In FY 1987, HCFA is requesting a contingency fund of $20 million for the Medicare Contractor program.

- A special legislative contingency fund of $18.7 million is included in our FY 1987 request. The operating contingency fund is reserved for unanticipated workload or other operating costs which cannot be otherwise absorbed. The use of the operating contingency for legislative items is not appropriate. However, 3 FY 1986 proposed law items of Home Health Agency ($2.0 million), Working Aged ($15.0 million) and extension of the Physician Fee Freeze ($1.7 million) will have a significant impact on the Medicare Contractor Budget. These proposed items are not normally funded out of operating contingency funds listed above.

FY 1987

STATE CERTIFICATION

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Decision Unit - STATE CERTIFICATION
(Budget Account - 75-0511-0-1-550)

Analysis of Resources
(Dollars in Thousands)

Total Program Level:	FY 1985	FY 1986	FY 1987
Total Obligations	$49,759	$49,759	$60,069
Less Trust Funds Transfers	$47,074	$48,434	$56,544
Total Budget Authority	$2,685	$1,325	$3,525

Total Program Level:	FY 1988	FY 1989	FY 1990	FY 1991
Total Obligations	$66,608	$73,300	$80,212	$87,324

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE STATE CERTIFICATION

Authorizing Legislation - Title XVIII, Social Security Act as amended, Section 1864.

Purpose and Method of Operations:

The purpose of the State Certification program is to ensure that institutions and agencies providing health care services to Medicare and Medicaid beneficiaries meet Federal standards for health quality and safety. The State administered Medicaid survey and certification program is also provided funding and oversight by the Health Care Financing Administration (HCFA). Federal financial participation for this activity is included in the Grants to States for Medicaid account.

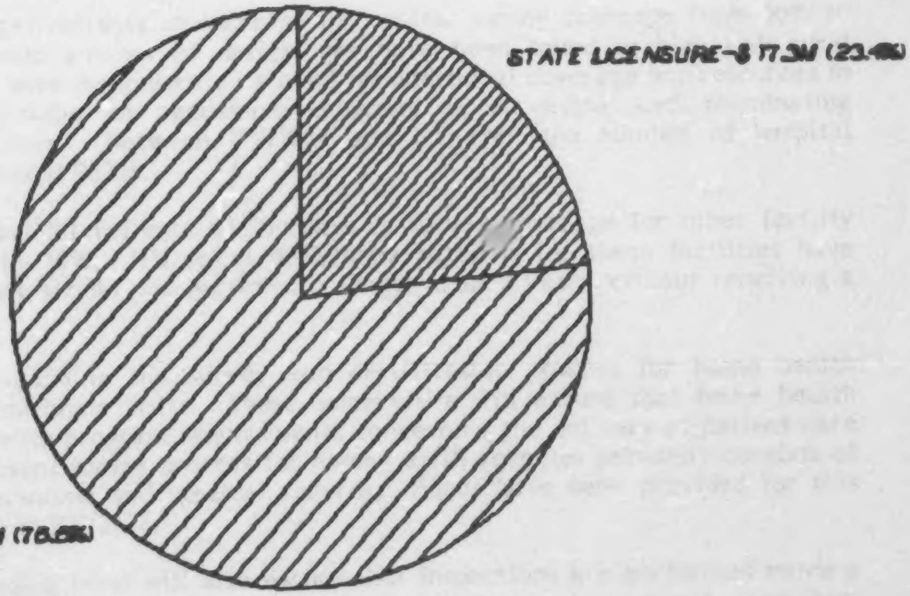
The State Certification program has been in existence since 1966 and initially covered hospital inspections. With the growth of the health care industry since then (both in services and facilities), Medicare and Medicaid coverage has expanded to include numerous types of providers and suppliers. This increase in facilities has expanded program activity from inspection of a few thousand hospitals in 1966 to oversight of approximately 47,470 diverse health care facilities in FY 1987. As a result of implementation of the Prospective Payment System, expansion in both the number and type of participating facilities is expected to continue in the future, challenging Federal and State governments to become increasingly efficient and to ensure that facilities meet prescribed health and safety conditions. As part of this process, HCFA is committed to identifying facilities that are in noncompliance with health and safety conditions and to ensuring that corrections are made or, if necessary, terminating them from program participation. For example, the program has been successful in eliminating facilities that fail to maintain key physical plant and life safety standards. This has virtually eliminated multiple death fire disasters within certified long-term care facilities.

An annual agreement, budget and workplan is negotiated with each State licensure agency (generally within the State Health Department) to perform onsite health facility inspections in accordance with explicit Departmental regulations and HCFA instructions. Qualified State specialists survey institutions to determine eligibility for Medicare program participation and, based on findings, make certification recommendations to the appropriate HCFA regional office responsible for final determination regarding facility participation. If the surveyed facility is found to have deficiencies, a plan of correction is developed. The majority of facilities correct cited deficiencies, thus permitting continued program participation. Facilities that do not make necessary corrections within a prescribed amount of time are eliminated from the program. To ensure States are conducting surveys in accordance

with explicit criteria and instructions, Federal staff perform random monitoring surveys. Results are provided to States together with technical assistance to implement any recommended improvements to the survey process.

States submit detailed line item budgets each year for the estimated costs of performing survey activities. The budgets are negotiated with HCFA program and fiscal specialists and are driven by person year requirements and associated salaries, fringe benefits, travel, training and indirect costs. HCFA requires States to submit quarterly cost and workload reports that are subject to DHHS audit by the Department's Office of the Inspector General. Since State Licensure programs simultaneously benefit from survey efforts, States assume a share of total survey costs which averages approximately 23.4%. The following chart shows the proportion of program costs shared by State licensure programs.

TOTAL MEDICARE INSPECTION COSTS



Relationship to Other Programs:

The State certification program is an integral part of both Medicare and Medicaid programs. Health facilities are eligible to provide services to Medicare and Medicaid beneficiaries if they receive a certification that acceptable standards of health safety and quality have been met. Reimbursement is only provided to those facilities that possess a certification. This provides assurance to Medicare and Medicaid beneficiaries that products and services offered by certified health facilities will be delivered at an acceptable level.

Rationale for the Budget Request:

The FY 1987 request is $60,069,000, an increase of $10,310,000 above the level of support as proposed in FY 1986. The requested amount will support an acceptable level of survey coverage for each facility type, including initial surveys of new facilities requesting program participation and necessary complaint and/or followup visits for those currently certified. To accomplish this workload, States will require 560 non long-term care and 415 long-term care staff.

The requested level of funding provides survey coverage for approximately 68 percent of facilities participating in the Medicare program. An annual survey has been budgeted for each long-term care facility to ensure that these providers comply with program standards. This plan supports HCFA's commitment to Congress to await recommendations of a study by the National Academy of Sciences that evaluates the long-term care certification process (to be completed by July 29, 1985) prior to determining if an alternative survey frequency should be implemented for such facilities. Remaining non long-term care facilities are on flexible survey cycles depending on their past compliance history. In any case, each facility would receive an onsite inspection at least once every two years.

The FY 1987 budget reflects an increase in hospital survey coverage from 50% to 75%. An inordinate amount of deficiences have been found in high risk rural hospitals. States have demonstrated a need for additional coverage and resources in this area to continue an aggressive program of surveying and terminating substandard facilities. Between FY/1983 and FY 1984 the number of hospital terminations increased 237%.

In addition, the budget reflects an increase in survey coverage for other facility types from 35% to 50%. Historical deficiency patterns for these facilities have indicated that they should not participate longer than 2 years without receiving a survey.

HCFA is also expanding the survey and certification process for home health agencies to include home visits. These home visits will ensure that home health agencies comply with program requirements concerning the delivery of patient care services. The present survey process for home health agencies primarily consists of the review of personnel and medical records. Funds have been provided for this activity beginning in FY/1987.

The budgeted funding level will also ensure that inspections are performed twice a year for facilities having deficiencies on previous surveys that, if not corrected, could adversely affect the life and health safety of beneficiaries. Approximately 78% of all facilities (175% long-term care and 40% non long-term care) will receive complaint investigations and/or onsite followup surveys to ensure cited deficiencies have been corrected. HCFA estimates the cost of these required visits to be one-third that of a full survey. Remaining funds

Relationship to Other Programs

The State certification program is an integral part of both Medicare and Medicaid programs. Health facilities are eligible to provide services to Medicare and Medicaid beneficiaries if they receive a certification that acceptable standards of health safety and quality have been met. Reimbursement is only provided to those facilities that possess a certification. This provides assurance to Medicare and Medicaid beneficiaries that products and services offered by certified health facilities meet or [illegible].

Rationale for the Budget Request

The FY 1987 request of $80,000,000 is an increase of $[illegible] above the level of support as proposed in FY 1986. The requested amount will support an increased level of survey cover for all institutional types, including [illegible] surveys of new facilities [illegible] and [illegible] visits [illegible] currently certified. [illegible] long term care [illegible].

The requested level of funding provides survey coverage for approximately [illegible] percent of facilities [illegible]. An annual survey has been [illegible] to ensure that these facilities comply with [illegible]. HCFA [illegible] National Academy of Sciences [illegible] 1985 [illegible] survey frequency should be [illegible] for each facility. [illegible] each facility would receive [illegible] every two years.

The FY 1987 request reflects an increase in hospital survey coverage from 5% to 27%. [illegible] 1986 and FY 1987 [illegible].

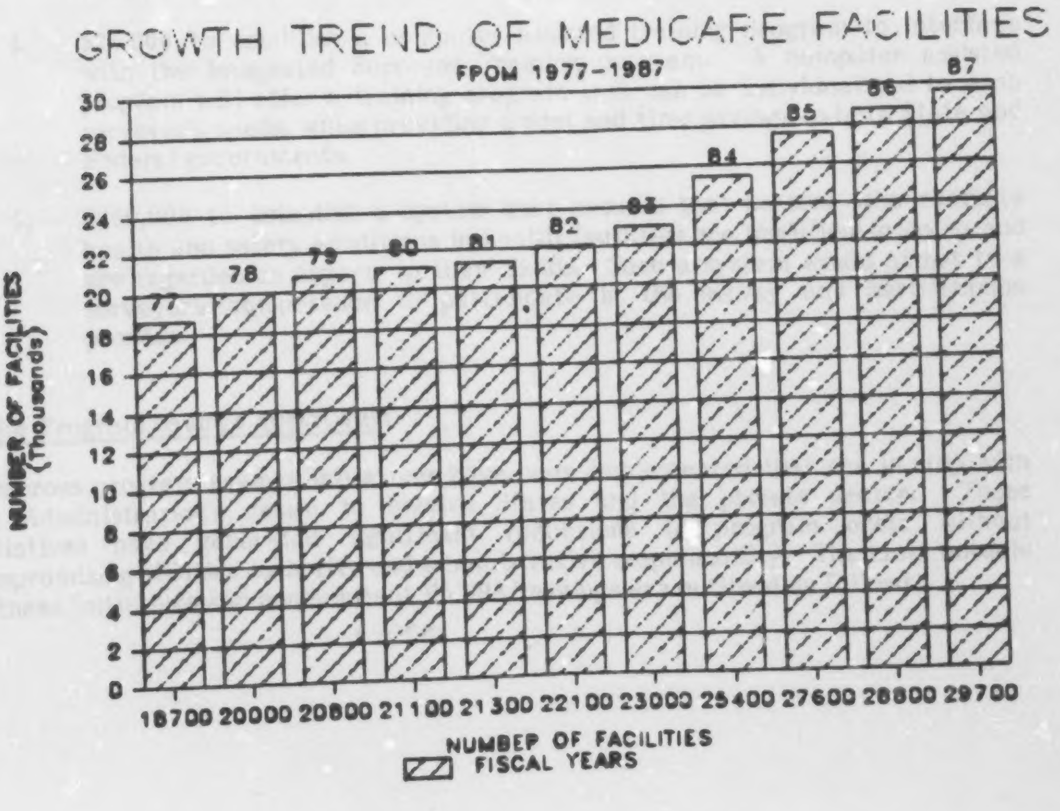
In addition, the budget reflects an increase in survey coverage for other facility types from 78% to 90%. [illegible] indicated that they should not go longer than 3 years without receiving a survey.

HCFA is also extending the survey and certification process for home health agencies to include home visits. These home visits will ensure that home health agencies comply with program requirements concerning the delivery of patient care services. The present survey process for home health agencies primarily consists of the review of personnel and medical records. Funds have been provided for this activity beginning in FY 1987.

The budgeted funding level will also ensure that inspections are performed twice a year for facilities having deficiencies on previous surveys that, if not corrected, could adversely affect the life and health safety of beneficiaries. Approximately 78% of all facilities (77% long-term care and 83% non long-term care) will receive [illegible] investigations [illegible] to ensure cited deficiencies have been corrected. HCFA estimates the cost of these [illegible] visits [illegible] will be used for surveying facilities with less severe deficiencies and those with a good compliance history. In addition, inspection costs for Skilled Nursing Facilities (SNFs) that participate in both Medicare and Medicaid programs are shared equally between the two programs.

The budget request excludes funds for the inspection of hospices. The hospice benefit expires September 30, 1986. Should the benefit be extended, this budget request will be amended to include the cost of inspecting these facilities which is estimated to be $610,000.

States will be provided funds to inspect an estimated 1,260 additional providers and suppliers that require an initial survey for program participation. This projected increase is based on past program growth experience together with anticipated increases due to the implementation of the Prospective Payment System for hospitals. HCFA believes that hospitals may provide shorter recuperative treatments and encourage beneficiaries to use the services of other providers and suppliers for needed therapy, rehabilitation, etc. This "unbundling" of services will result in additional providers and suppliers seeking program participation. The following chart displays the growth trend of Medicare facilities from 1977 through 1987.



The requested funding level will provide a total of $3,525,000 in FY 1987 contract support for the following activities:

1. $2,500,000 is required for the oversight of two special conditions in the 470 psychiatric hospitals certified for participation in the Medicare/Medicaid programs. The contractor will be responsible for providing qualified mental health consultants, scheduling and conducting surveys, and providing expert technical assistance and consultation to providers, HCFA RO staff, and State agencies. This budget assumes passage of a proposal which eliminates the option that States currently have to survey the two special conditions. The budget assumes 100% federal surveys. Corresponding adjustments have been made to delete funds for the cost of the States' surveys.

2. $200,000 to assist HCFA in the oversight of laboratories in the highly specialized area of cytology testing. A major problem in the survey of cytology laboratories is that generally State surveyors are neither trained, nor qualified in the area of cytology.

3. $600,000 to develop an outcome oriented survey process for other facility types, e.g., HHAs. HCFA has implemented a patient care assessment tool in SNFs and ICFs and believes that other facility types would benefit from a similar survey process. This contract will assist HCFA in developing a revised survey process for these facility types.

4. $25,000 to establish a computer assisted training program to interface with the Integrated Surveyor Training program. A computer assisted program will offer a training program that can be individualized to each surveyor's needs, while providing a cost and time savings to both State and Federal governments.

5. $200,000 to establish a system that ensures that persons who evaluate health and safety conditions in health facilities are qualified to do so and are regarded as experts in their fields. Such a system would attest to a surveyor's competence to participate in the survey and certification process.

Major Program Savings Initiatives:

Numerous program savings initiatives have been implemented that are in step with the Administration's desire to involve States and the private sector. These initiatives have generated significant reductions to program costs without compromising HCFA's authority and administrative responsibility. The most notable of these initiatives and concomitant FY 1987 savings are outlined as follows.

Federal/State Partnership - Recognizing that the same State survey agency simultaneously inspects for both State licensure conditions and Federal Medicare conditions, HCFA requires the States to share equally in the cost of inspection for those conditions that are required by both programs. The current negotiated percentages average 23.4% of total costs. The FY 1987 savings to the Medicare program is estimated to be $17,273,000.

Less Frequent than Annual Surveys - To maximize use of resources and reduce the inspection burden on those facilities with a good compliance history, HCFA has implemented flexible survey cycles for inspecting non long-term care facilities. Facilities are surveyed on a one or two year survey cycle depending on past performance. In FY/1987, the less frequent than annual survey initiative for non long-term care facilities will save approximately $20,237,000.

Sharing of Survey Costs for Title XVIII/XIX SNFs - To eliminate the duplication inherent in the surveys conducted in SNFs that participate in both Medicare and Medicaid programs, HCFA requires that one survey be completed that meets the requirements of both programs. The cost of surveying XVIII/XIX SNFs are shared equally between the two programs. The savings to the Medicare program for FY/1987 is estimated to be $19,351,000.

Deeming - The budget for FY 1987 reflects an estimated $18,496,000 savings to the program from the deeming of approximately 5,080 (at 50% coverage) hospitals accredited by the Joint Commission on Accreditation of Hospitals. While HCFA is currently exploring the use of other accrediting organizations we cannot project which organizations will be given deemed status and the subsequent cost savings. Before granting deemed status, an accrediting organization must request recognition of its accreditation program for deeming purposes. After receiving such a request, HCFA evaluates the organization's standards and its method of operation to determine whether accreditation by the organization is sufficient assurance of compliance with Medicare requirements. This evaluation process is very lengthy, requiring extensive, indepth reviews and involves reviews by various components within the Administration and Congress together with the private sector.

Major Program Enhancement Initiatives:

The State Certification program is continuously improved through the following program enhancement initiatives:

HCFA will aggressively seek out those facilities that are out of compliance with program standards and ensure corrections are made or, if necessary, terminate them from program participation. The majority of facilities correct the deficiencies, thus permitting continued program participation. However, some facilities that cannot or refuse to take corrective action to meet minimum Federal requirements might still participate if surveys were not carried out and certification standards not required (i.e., providing services under life threatening conditions while receiving Federal reimbursement). Therefore, it is necessary to process termination actions against such facilities, and in FY 1984, HCFA terminated 865 facilities.

HCFA is working toward national implementation of intermediate sanctions. Medicare payments will be denied to a long-term care facility for new admissions, in lieu of termination, if it is determined that the facility does not meet one or more conditions of participation and the facility's deficiencies pose no immediate jeopardy to patients' health and safety.

HCFA will continue to analyze and implement revisions to survey report forms together with modifications to improve the actual onsite survey process. These changes are designed to provide more specific and valid/reliable documentation of surveyors' observations in areas where conditions of participation have not been met. Such documentation will provide stronger support to enforce corrective action and, in more serious instances, initiate termination procedures.

HCFA is developing a revised review form and guidelines for nursing home services to allow surveyors to evaluate a facility based on patient care outcomes rather than the facility's capacity to provide services. Compliance decisions for specific conditions are based on the surveyor's observation of the patient's physical condition, actual care rendered to the patient, patient interview, and medical record review. This Patient Care and Services initiative will be implemented in FY 1986. HCFA plans to conduct a major evaluation of State application of the form and implement improvements as necessary.

Congressional concern over the quality of care provided in psychiatric hospitals has prompted HCFA to reevaluate the level of effort devoted to the survey of these providers. In FY 1987 HCFA plans to increase its oversight responsibility of the estimated 470 psychiatric hospitals to 100% survey coverage conducted by psychiatric consultants approved by HCFA together with random monitoring surveys by HCFA regional staff. This initiative would encompass the 2 special condition surveys in 190 facilities that are currently performed by the States. $2,500,000 is requested for the authority based on FY 1985 contract negotiations requiring $715,000 for 125 surveys.

HCFA is exploring the issue of expanding deeming and is considering several requests to recognize the decisions of national accrediting bodies in determining whether providers and suppliers of health care services meet the requirements for Medicare participation. HCFA is developing a review mechanism to deal equitably with all requests for recognition. HCFA will also develop validation procedures specific for each type of provider granted deemed status.

HCFA is developing regulations and guidelines that will streamline and improve the quality of facility surveys and patient care reviews through less frequent than annual reviews, patient sampling, focused facility reviews, etc. These actions will promote the Administration's goal to maintain an adequate level of beneficiary care in a safe and sanitary environment yet reduce the burden from unnecessary inspections of those providers and suppliers with a history of compliance.

STATE CERTIFICATION WORKLOAD FUNDING REQUIREMENTS

(Budget Column in Thousands)

	FY 1984							FY 1985						
	# Facilities	# Surveys	% Coverage	Unit Cost	# Followup/ Complaint	Unit Cost	Budget	# Facilities	# Surveys	% Coverage	Unit Cost	# Followup/ Complaint	Unit Cost	Budget
Medicare														
SNF XVIII	285	285	100	$3,335	500	$1,110	$ 1,505	355	355	100	$3,500	620	$1,155	$ 1,960
SNF XVIII/XIX	5,505	5,505	100	3,335	9,635	1,110	14,527	5,880	5,880	100	3,500	10,290	1,155	16,229
Hospital (Non-Accr.)	1,560	780	50	5,000	625	1,665	4,941	1,500	750	50	5,250	600	1,750	4,988
HHA	4,280	1,710	40	2,125	1,710	710	4,848	5,345	2,830	53	2,230	2,140	740	7,895
ESRD	1,210	485	40	2,125	485	710	1,375	1,350	770	57	2,230	540	740	2,117
Lab	3,740	1,870	50	2,125	1,495	710	5,035	3,925	2,355	60	2,230	1,575	740	6,417
Hospice	180	180	100	2,125	70	710	432	210	210	100	2,230	85	740	531
Other	3,630	1,895	32	2,125	1,425	710	5,035	3,845	2,600	67	2,230	1,540	740	6,937
TOTAL	20,390	12,995	64%	$2,820	13,945	$1,000	$37,698	22,410	15,750	70%	$2,875	17,390	$1,035	$47,074

	FY 1986							FY 1987						
	# Facilities	# Surveys	% Coverage	Unit Cost	# Followup/ Complaint	Unit Cost	Budget	# Facilities	# Surveys	% Coverage	Unit Cost	# Followup/ Complaint	Unit Cost	Budget
Medicare														
SNF XVIII	365	365	100	$3,665	640	$1,220	$ 2,119	375	375	100	$3,835	655	$1,275	$ 2,273
SNF XVIII/XIX	6,130	6,130	100	3,665	10,730	1,220	17,779	6,380	6,380	100	3,835	11,165	1,275	19,351
Hospital (Non-Accr.)	1,300	750	50	5,495	600	1,830	5,219	1,500	1,125	75	5,040[5]	600	1,680	6,678
HHA	5,865	3,110	53	2,335	2,345	775	9,079	6,385	3,385	53	2,440	2,555	815	10,342
ESRD	1,400	800	57	2,335	560	775	2,302	1,450	825	57	2,440	580	815	2,486
Lab	4,005	2,405	60	2,335	1,600	775	6,856	4,085	2,450	60	2,440	1,635	815	7,311
Hospice[4]	215	215	100	2,335	85	775	568	-	-	-	-	-	-	-
Other	4,035	1,395	33	2,335	1,615	775	4,512	4,225	2,115	50	2,440	1,690	815	6,539
TOTAL	23,313	15,170	63%	$3,060	18,173	$1,090	$48,434	24,400	16,655	68%	$3,180	18,880	$1,130	$54,980
Home Health Visits								1,275[2]	6,385[3]	100%	245 N/A	N/A	$ 1,564	$56,544

Computation per type of Facility: (Total Facilities x Coverage x Unit Cost) + (Followup/Complaint x Unit Cost) = Budget[1]

[1] SNF XVIII/XIX facilities use the same computation . However, Medicare's share is 50% of the total cost, and Medicaid's share is 50% of the total cost.

[2] Represents 20% sampling of total HHAs

[3] Each HHA sampled receives 5 home visits.

[4] Hospice benefit expires 9/30/86.

[5] Hospital unit cost is reduced due to HCFA consultants surveying 2 special conditions in 100 percent of psychiatric hospitals.

STATE CERTIFICATION
PARTICIPATING MEDICARE/MEDICAID HEALTH CARE FACILITIES

	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991
MEDICARE									
Hospitals	6,615	6,710	6,695	6,735	6,775	6,815	6,855	6,895	6,935
(Non-Accredited)	(1,550)	(1,560)	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)	(1,500)
(Psychiatric)	(420)	(435)	(450)	(460)	(470)	(480)	(490)	(500)	(510)
SNFs (XVIII only)	275	285	355	365	375	385	395	405	415
SNFs (XVIII/XIX)	5,255	5,505	5,880	6,130	6,380	6,630	6,880	7,130	7,380
Home Health Agencies	3,670	4,280	5,345	5,865	6,385	6,905	7,425	7,945	8,465
Independent Laboratories	3,660	3,740	3,925	4,005	4,085	4,165	4,245	4,325	4,405
End-Stage Renal Disease	1,200	1,210	1,350	1,400	1,450	1,500	1,550	1,600	1,650
Portable X-Ray	260	265	285	300	315	330	345	360	375
Outpatient Physical/Speech Therapy	635	715	835	915	995	1,075	1,155	1,235	1,315
Rural Health Clinics	420	420	435	445	455	465	475	485	495
Independent Practicing Physical Therapist	1,775	1,910	1,975	2,005	2,035	2,065	2,095	2,125	2,155
Ambulatory Surgical Centers	50	150	255	305	355	405	455	505	555
Comprehensive Outpatient Rehabilitation Facilities	50	55	60	65	70	75	80	85	90
Hospices	-	115	210	215	-	-	-	-	-
SUBTOTAL	23,865	25,360	27,605	28,730	29,675	30,815	31,955	33,095	34,235
MEDICAID									
SNFs (XIX only)	2,495	2,485	2,410	2,320	2,320	2,320	2,320	2,320	2,320
ICFs	11,325	11,460	11,585	11,655	11,725	11,795	11,865	11,935	12,005
ICFs/MR	1,540	2,100	2,650	3,200	3,750	4,300	4,850	5,400	5,950
SUBTOTAL	15,360	16,045	16,645	17,175	17,795	18,415	19,035	19,655	20,275
TOTAL MEDICARE/MEDICAID	39,225	41,405	44,250	45,925	47,470	49,230	50,990	52,750	54,510

FY 1987

ESRD NETWORK COORDINATING COUNCILS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Decision Unit- ESRD NETWORK COORDINATING COUNCILS
(Budget Account - 75-0511-0-1-550)

Analysis of Resources
(Dollars in Thousands)

Program Level:	FY 1985	FY 1986	FY 1987	
Total Obligations	$ 4,837	$ —	$ —	
Program Level:	FY 1988	FY 1989	FY 1990	FY 1991
Total Obligations	$ —	$ —	$ —	$ —

Authorizing Legislation - Social Security Act, Title XVIII, Section 1881.

Purpose and Method of Operations:

Section 1881 of the Social Security Act authorizes the Secretary to establish and support renal disease network areas financed from the Medicare trust fund. The tremendous expansion and number of beneficiaries together with the size of the Federal investment in End Stage Renal Disease (ESRD) benefits necessitated the establishment of a mechanism to promote quality assurance and the effective and efficient utilization of resources in the delivery of services to ESRD patients.

To accomplish these goals, HCFA established 32 ESRD Network Coordinating Councils. These Councils now focus the majority of their efforts in the following areas: (1) quality of care activities; (2) ESRD program studies and initiatives to identify and resolve problems; (3) provision of data for facility approval; and (4) provision of patient-specific data.

Each of the 32 Network Coordinating Councils (NCCs) has a Medical Review Board, an executive committee, and a staff responsible for the administrative and fiscal management of Council activities. The Medical Review Board is composed of voluntary members, which include one representative from each area dialysis and transplant facility as well as at-large members representing ESRD patients and other social, medical, or technical disciplines involved in the delivery of care.

An annual agreement is negotiated with each Council that outlines its responsbility with regard to administration of Council objectives. Councils submit detailed budgets for estimated annual costs that are subject to Federal approval. NCC cost reports are submitted on a quarterly basis and are subject to audit by the Department's Office of the Inspector General.

Rationale for the Budget Request:

As a management improvement to streamline administration, the FY 1987 budget request assumes that the activities which the Councils perform, including new functions as specified by the Deficit Reduction Act of 1984, will be assigned in FY 1986 to other programs HCFA manages. For instance, HCFA has already employed management

improvements to address various Council responsibilities. Examples include: (1) the monitoring of facility compliance is adequately addressed by the certification function; and, (2) in areas where a certificate of need program exists, the need for Councils to play an advisory role in the process has been virtually eliminated. HCFA's recent establishment of a composite reimbursement rate for ESRD facilities should also promote home dialysis. HCFA believes it can successfully shift all Council activities to other programs, such as PROs, contractors, and other entities. These efforts will focus on maintaining quality of care and on gathering data similar to that currently collected by the Councils. These entities will be able to perform these functions more efficiently and effectively because they better reflect local needs and are involved in the full range of Medicare services delivered to beneficiaries with ESRD.

FY 1987

ADMINISTRATIVE COSTS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Decision Unit - ADMINISTRATIVE COSTS
(Budget Account 75-0511-0-1-5501)

Analysis of Resources
(In Thousands of Dollars)

Program Level:	FY 1985	FY 1986	FY 1987
Total Program Level	$221,227	$217,421	$258,012 3/
Total Obligations	221,227 1/	217,421 2/	223,912
Less Trust Fund Transfers	148,908	145,672	150,021
Budget Authority	72,319	71,749	85,144
Outlays	72,319	71,749	73,891
FTE Employment (workyears)	4,038	3,935	3,800

Program Level:	FY 1988	FY 1989	FY 1990	FY 1991
Total Program Level	$226,694	$229,370	$231,920	$234,557
Total Obligations	248,906	241,258	231,920	234,557
Less Trust Fund Transfers	151,885	153,678	155,386	157,153
Budget Authority	74,809	75,692	76,534	77,404
Outlays	82,139 4/	79,615 4/	76,534	77,404
FTE Employment	3,800	3,800	3,800	3,800

1/ Reflects lapse of $432,000 as required in Section 515 of the FY 1984 Treasury and Postal Appropriation Act.

2/ Includes proposed supplemental of $12,821,000 to fund an additional 135 FTEs and to restore funds deleted for the proposed FY 1986 pay cut of 5 percent.

3/ Includes proposed multi-year funding of $34,100,000 to fund PRISM.

4/ Includes $7,330,000 and $3,923,000 respectively in outlays associated with the multi-year funding of PRISM.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

ADMINISTRATIVE COSTS

Authorizing Legislation: Reorganization Act of 1953

Purpose and Method of Operations

The resources requested for the Administrative Costs budget activity are required to maintain effective and efficient management of the Medicare and Medicaid programs. In FY 1987, these programs will account, under current law, for over $107.9 billion of the Federal budget and will serve over 52 million people.

This budget activity addresses the operating expenses of the Health Care Financing Administration. Its funding is provided through the appropriation of General Treasury Revenues and transfers from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

In FY 1987, HCFA will continue to build on its initiatives to (1) safeguard the health and safety of Medicare beneficiaries and Medicaid recipients; and (2) promote competition, reduce unnecessary regulatory and administrative burdens, and introduce efficiencies in the Medicare and Medicaid programs.

Major Initiatives

Some of the major initatives that HCFA plans to undertake in FY 1987 are presented below:

The Prospective Payment System (PPS) for inpatient hospital services will be phased in over a 3-year period beginning in FY 1984. During this phase-in period, PPS payment rates will be a blend of hospital-specific amounts based on each hospital's cost experience and national and regional (for the nine census division) diagnosis related groups (DRG's) amounts for both urban and rural hosptials. In FY 1987, PPS payment rates will be determined strictly by the national DRG payment methodology. The implementation of PPS will require close monitoring of the performance of the Medicare contractors and effective cordination with the health care industry. In FY 1987, HCFA plans to identify and study alternative health care delivery and payment systems to control the costs of physician reimbursement, long-term care reimbursement (Medicaid), and other Medicare/Medicaid reimbursement processes without sacrificing the quality of care. The PPS will be refined, evaluated, and expanded to other types of providers and suppliers.

In FY 1984, HCFA entered into 2-year contracts with Peer Review Organizations (PRO's) to conduct various types of medical and utilization reviews under the PPS. Specifically, PRO's are responsible for reviewing admissions, day and cost outliers, DRG assignments, and quality of care issues. In FY 1986, the PRO contracts will be renewed for an additional 2-year period. The FY 1986 PRO contracts will be expanded to require reviews of services provided by HMO's, outpatient surgical units (both hospital-based and freestanding), and hospital discharges/transfers at or near time of discharge/transfer. These reviews are essential to assure proper, adequate and timely treatment for beneficiaries enrolled in HMO's, to assure that surgery determined to be unnecessary is not performed as outpatient surgery and to assure that charges are not inflated or unnecessary services are not provided to increase reimbursement. In FY 1987, HCFA will continue to oversee PRO activities and impose sanctions when the terms of the PRO contract are not being met.

In FY 1987, HCFA will design, develop and test the Medicare contractors model claims processing system that will be implemented in FY 1988. This model system will facilitate implementation of any new required system changes (such as fee freeze or prospective payment), decrease transition costs when it is necessary to remove workload from high-cost or poor-performing contractors, and result in programmatic savings since the system will be built to maximize edits to prevent overpayments.

In FY 1987, HCFA plans to intensify survey and certification coverage of psychiatric hospitals. Surveys are conducted by psychiatric consultants together with random monitoring surveys by HCFA regional staff. These surveys assure that State surveys eliminate poor quality providers that fail to meet Federal standards and to facilitate the placement into community settings of individuals inappropriately placed in institutions.

In FY 1987, HCFA will continue the Project to Redesign Information Systems Management (PRISM) which encompasses both long and short-term improvement for HCFA's ADP and telecommunications environment.

FY 1987 Budget Request
Administrative Costs
Object Classification

(Dollars in Thousands)

Object Class	FY 1985	FY 1986	FY 1987	Change
Total Personnel Compensation	$143,978	$139,387	$136,474	$ -2,913
Personnel Benefits	16,645	18,276	17,894	-382
Travel	5,460	5,640	5,877	+237
Transportation of Things	491	518	540	+22
Communication & Utilities	7,881	9,072	13,006	+3,934
Rents	10,885	11,347	12,115	+768
Printing	2,920	2,920	3,043	+123
Other Services	25,129	22,492	26,523	+4,031
Supplies and Materials	1,141	1,141	1,534	+393
Equipment	6,697	6,628	6,906	+278
Total Obligations	$221,227 [1]	$217,421 [2]	$223,912	$ +6,491
Total Program Level	$221,227	$217,421	$258,012 [3]	
FTEs	4,038	3,935	3,800	-135

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[1] Reflects lapse of $432,000 as required in 515 of the FY 1984 Treasury and Postal Appropriation Act.

[2] Includes proposed supplemental of $12,821,000 to fund an additional 135 FTEs and to restore funds deleted for the proposed FY 1986 pay cut of 5 percent.

[3] Includes proposed multi-year funding of $34,100,000 to fund PRISM.

RATIONALE FOR FY 1986 SUPPLEMENTAL REQUEST

The FY 1986 request for Administrative Costs is revised to include an additional $12,821,000. The supplemental funds will restore the funds that were omitted in anticipation of a proposed 5 percent employee pay reduction that was not enacted by Congress. Also, it funds 135 FTEs in addition to 3,800 FTEs included in HCFA's FY 1986 Congressional Request. Significant increases in program responsibility, such as implementation of TEFRA and DEFRA, imposed additional requirements on HCFA for which no additional positions were requested. Even with outside hiring restricted since January 1985 attrition will not be sufficient to reduce HCFA's FTE level to 3,980 in FY 1985 or to 3,800 in FY 1986.

Further, a policy of attrition is damaging to the Agency in that it does not allow for replacing losses in key positions that are necessary to function effectively and accomplish program objectives. During FY 1986, therefore, HCFA plans to hire one employee for each two losses. A hiring freeze during the first quarter of FY 1987 should then reduce staffing to 3,800 by the end of FY 1987.

RATIONALE FOR FY 1987 BUDGET REQUEST

The FY 1987 request for Administrative Costs of $223,912,000 is an increase of 3 percent over the revised FY 1986 request. This request will fund a level of 3,800 full-time equivalents (FTEs) that will enable this Agency to continue to perform the functions described in the "Functional Highlights and Accomplishments" section of this narrative. The FY 1987 level reflects a decrease in staff equivalent of 135 FTEs from the FY 1986 amended level. .

In general, all object classes are maintained at their FY 1986 levels, adjusted only for inflation. Exceptions to this current policy level are described below:

Personnel Compensation and Benefits

Included in the FY 1987 budget request is $154,368,000 to fund 3,800 FTEs. This amount reflects a decrease of $3,295,000 from the revised FY 1986 request as show below:

- a $612,000 increase for the one additional work day in FY 1987
- a $1,577,000 increase for employee within grades
- a $5,484,000 decrease for costs associated with the reduction of 135 FTEs

Rents, Communications and Utilities

Included in the FY 1987 budget request is $25,121,000 to fund rent, communication and utility costs. This amount reflects an increase of $4,702,000 over the revised FY 1986 request. This increase includes $73,000 for inflation plus the following items:

- $1,424,000 for rate increases specified for space rental, postages and telecommunications.
- $205,000 for increased costs associated with the Agency's on-going ADP operations.
- $3,000,000 to reimburse the Social Security Administration for HCFA's -

The largest component of these costs is the Agency's space rental, which is billed directly by and paid to the General Services Administration (GSA). These rates are established by GSA and affect all of the buildings occupied by HCFA staff in Washington, D.C. Woodlawn, Maryland, and in each of the 10 regional offices. The Agency's space rental cost is expected to increase $768,000 over the FY 1986 request due to an anticipated rate increase. It should be noted that under the Department's work-space management plan, the Agency has reduced its Washington, D.C. and Woodlawn, Maryland space in accordance with the new GSA space regulation. Since the 10 regional offices fall under the auspices of the Office of the Secretary, the Agency has no contol on policy decisions affecting regional office space.

The budget request also reflects necessary increases of $217,000 for postage costs and $439,000 for telecommunications.

In November 1983, HCFA and the Social Security Administration (SSA) were instructed by the Assistant Secretary for Management and Budget to jointly explore the technical and economical feasibility of integrating their telecommunication requirements into a single voice/data switching system to serve all activities in the Woodlawn, Maryland complex. The estimated total cost of the system $15,000,000 of which HCFA's portion will be $3,000,000. The system is made up of 4 major parts: instruments (phones), internal lines, multiplexers, and three central processing units, one of which will be dedicated to HCFA. HCFA is scheduled to be hooked up into the system in January, 1987. The $3,000,000 covers the cost of installation of all the components of the system as well as service for a 10-year period.

Other Services

Included in the FY 1987 budget request is $26,523,000 for Other Services. This amount reflects an increase of $4,031,000 over the FY 1986 request as shown below:

- an increase of $945,000 for inflation.
- a decrease of $1,774,00 for costs associated with the reduction of 135 FTEs.
- an increase of $4,560,000 for PRISM.
- an increase of $300,000 for increased machine repairs associated with the Agency's on-going ADP operations.

The request includes an increase of $4,560,000 for HCFA's long-range data planning initiative, Project to Redesign Information Systems Management (PRISM). FY 1987 is a critical year in HCFA's PRISM effort because major portions of the redesign are scheduled in that year. During FY 1987, HCFA intends to construct data bases for the Health Insurance/Supplemental Medical Insurance (HI/SMI) System, the Medicare/Medicaid Statistical System (M/MSS), the Program Management System, and the Administrative System; construct a test system for the HI/SMI System; and construct data conversion systems for the HI/SMI and M/MSS. In addition, another PRISM data processing contract in FY 1987 is to continue the Systems Integration effort, which will provide technical assistance to HCFA staff and provide continuity between the various redesign contractors. This request is consistent with the 5-year plan recently submitted to the Assistant Secretary of Management and Budget.

The largest component of these costs is the Agency's space rental, which is billed directly by and paid to the General Services Administration (GSA). These rates are established by GSA and reflect all of the buildings occupied by HCFA staff in Washington, D.C., Woodlawn, Maryland, and in each of the 10 regional offices. The Agency's space rental costs are expected to increase $565,000 over the FY 1986 request due to an anticipated rate increase. It should be noted that under the Department's workspace management plan, the Agency has reduced its Washington, D.C. and Woodlawn, Maryland space in accordance with the new GSA space regulations. Since the 10 regions' offices fall under the purview of the Office of the Secretary, the Agency has no control on policy decisions affecting regional office space.

The budget request also reflects increases of $231,000 for postage costs and $479,000 for telecommunications.

In February 1985, HCFA and the Social Security Administration (SSA) were instructed by the Assistant Secretary for Management and Budget to jointly evaluate the technical and economical feasibility of integrating their telecommunication requirements into a single voice/data system, and then to serve as a pilot for the Department's network. The estimated total cost of the system is $17 million, of which HCFA's portion will be $3,209,000. The system is made up of 4 major parts: three data network equipment, multiplexers, and three central processing units, the cost of which will be allocated to HCFA. HCFA is scheduled to be connected to the system in January 1987. The $3,209,000 covers the cost of installation of all the components of the system, as well as service for a 12-month period.

Other Services

Included in the FY 1987 budget request is $56,725,000 for Other Services. This amount reflects an increase of $5,251,000 over the FY 1986 request as shown below:

- o an increase of $356,000 for printing;
- o a decrease of $1,774,000 for costs associated with the reduction of 150 FTEs;
- o an increase of $5,981,000 for PRISM;
- o an increase of $700,000 for increased building repairs associated with the Agency's ongoing ADP operations.

The request includes an increase of $5,981,000 for HCFA's long-range data processing initiative, Project to Redesign Information Systems Management (PRISM). FY 1987 is a crucial year in HCFA's PRISM effort because major portions of the redesign are scheduled in that year. During FY 1987, HCFA intends to construct data bases for the Health Insurance/Supplemental Medical Insurance (HI/SMI) System, the Medicare/Medicaid Statistical System (M/MSS), the Program Management System, and the Administrative Systems; construct a test system for the HI/SMI System; and construct data conversion systems for the HI/SMI and M/MSS. In addition, another PRISM data processing contract in FY 1987 is to continue the Systems Integration effort, which will provide technical assistance to HCFA staff and provide continuity between the various redesign contractors. This request is consistent with the report recently submitted to the Assistant Secretary of Management and Budget.

The increase of $300,000 is requested for automated data processing maintenance costs due to the increased number of microcomputers and electronic word processors used by the Agency.

Supplies and Materials

Included in the FY 1987 budget request is $1,534,000 for supplies. This amount reflects an increase of $393,000 over the FY 1986 request. This increase includes $48,000 for inflation and $345,000 for for automated data processing supplies due to the increased number of microcomputers and electronic word processors used by the Agency.

RATIONALE FOR MULTI-YEAR FUNDING AUTHORITY-PRISM

For the last three years, HCFA has had to justify the incremental funding of its PRISM plan. In order to improve our ability to manage this project on a long-range basis, and to better inform the Administration and the Congress of the out-year implications of our project, multi-year budget authority is requested. It would appear strategically advantageous to HCFA to receive Departmental and Executive Office of Management and Budget approval for the entire PRISM plan. This is the same type of funding SSA is using to fund their modernization plan.

This would mean requesting total PRISM resources of $44.2 million in FY 1987 (an increment of $34.1 million above the anticipated obligations for FY 1987) which would be outlayed over a 3-year period. Although this would eliminate the need for justifying yearly increments to the Congress, these funds would still be subject to a yearly apportionment. This would also result in better management of the program. Future planning could proceed with the complete knowledge of the Administration's commitment. Furthermore, HCFA could manage the program more effectively.

Another advantage of this funding would be that of informing the Congressional Committees and the Executive Branch of the complete implications of our entire long-range Agency plan rather than providing incremental information each fiscal year.

RATIONALE FOR FULL TIME EMPLOYMENT REQUEST

HCFA is requesting an FTE ceiling of 3,935 in FY 1986 and 3,800 in FY 1987. In order to place this request in context, it is necessary to understand the actions that HCFA has taken to date to manage to reduce FTE levels as well as to understand the programmatic and management implications to this Agency of a further reduction in FTE ceiling.

HCFA's Approach To FY 1985/86 Ceiling Reductions

HCFA addressed the FY 1985/86 ceiling reductions by deciding at the outset that it was inconsistent with both the spirit of reform and the principles of good management to reduce components' employment ceilings whenever attrition occurred. It was decided that the Agency's total employment level would be

allowed to decrease by following a principle of attrition, but that priorities would be established to allocate available FTEs. Efforts would be made to reallocate employees from low-priority to high-priority functions. In this way the devastating morale effects of a Reduction-in-Force (RIF) would be avoided and, at the same time, HCFA would be streamlined to accomplish its mission within the constraints of a 3,800 FTE ceiling.

This process was begun by having the Associate Administrators assess which functions were of highest and lowest priority and the allocation of resources within their areas. The basic objective was to streamline administrative staff as well as to reduce those functions that were less essential to the mission of the Agency. This analysis resulted in ceilings that became employment targets for each Associate. The result of this process can be seen in the following table and is discussed in more detail below.

	On-Board	Projected Distribution Through Attrition	1986 Ceiling	Percent Change
Associate Administrator for Management and Support Services				
Office of Management and Budget	490.0	449.5	412.5	-15.8
Bureau of Data Management and Strategy	359.2	330.0	320.7	-10.7
Office of the Actuary	62.8	58.0	59.0	-6.1
Other	18.0	16.8	22.8	+26.7
Subtotal	930.0	854.3	815.0	-12.4
Associate Administrator for Operations				
Bureau of Program Operations	454.2	422.7	423.2	-6.8
Bureau of Quality Control	215.0	200.1	186.1	-13.4
Health Standards and Quality Bureau	175.0	159.7	171.3	-2.1
Regional Offices	1558.4	1450.0	1485.0	-4.7
Other	17.0	15.8	14.8	-12.9
Subtotal	2419.6	2248.3	2280.4	-5.8
Associate Administrator for Policy	572.0	532.4	539.6	-5.7
Associate Administrator for External Affairs	70.4	65.0	65.0	-7.7
Other	108.2	100.0	100.0	-7.3
Total HCFA	4100.2	3800.0	3800.0	-7.3

This table displays the employees on-board as of February 1985 and the drop in employment that will occur by attrition assuming that employees attrit equally throughout the Agency. The 1986 ceiling column reflects the Agency ceiling after the assessment of priority areas was made. As this table displays, the organizations receiving the largest percentage reductions when the 1986 ceiling is compared with the on-board employment were the Office of Management and Budget (OMB) and the Bureau of Quality Control (BQC). While each component has developed a strategy for achieving these goals, those of OMB and BQC are described in more detail since their reductions are the most significant.

Office of Management and Budget

Reductions in the OMB would primarily come from reductions in management and administrative activities staff. This would mean:

(1) Reducing HCFA efforts in special organizational analyses, management consulting, information collection budget, guides for paperwork burden reduction and operational consistency. We would, however, continue to target our efforts in areas such as the Administrator's workplan, essential HCFA management control processes, HCFA-wide management analysis, internal control projects, and the review of new paperwork requirements.

(2) Reducing general services activities in lower priority areas (e.g., space management and printing) and contracting out functions whenever possible (i.e., warehouse), automating manual systems to the greatest extent possible, and reorganizing for greater efficiency.

(3) Reducing the Medicare Operations Support resource levels responding to beneficiary and intermediary inquiries about Medicare premiums, eligibility, etc., significantly by automating the replies to incoming correspondence. A pilot is planned to begin late in FY 1985 and should be operational by late FY 1986.

Bureau of Quality Control

The Bureau of Quality Control reductions will be accomplished by reducing the scope, while maintaining the critical elements, of four activities.

(1) Medicaid Eligibility Quality Control (MEQC) FTE resources will be saved by reducing Federal sub-samples. While we cannot precisely estimate the extent to which this will erode our position in pursuing withholdings or disallowances, these reduced sub-samples will be targeted to minimize this adverse impact.

(2) Systems Performance Reviews (SPR) and Claims Processing Assessment Systems (CPAS). SPR are annual reviews to ensure acceptable performance levels of States' Medicaid Management Information Systems for which the Federal Government reimburses the States at incentive matching rates. CPAS is the quality control review of States' claims processing systems to ensure low claims payment error rates. FTE savings in these reviews will be achieved by eliminating some of the factors being reviewed, reducing some documentation requirements for elements receiving a passing grade and by eliminating early warning system requirements.

(3) State Assessments State Assessments are annual reviews of State policies and operations to ensure consistency with Federal requirements. These reviews are directed towards problem identification and solution. Resource levels will be reduced by restricting general review activities to central elements of priority Federal requirements and undertaking special focus reviews in high risk States and/or high visibility issue areas. This will result in more focused reviews although less information will be available to assure that States are meeting regulatory requirements.

(4) Operational Reviews These reviews are comprehensive analyses and studies of Medicaid program policies and operations. They frequently build on State assessment findings by addressing issues and problems which are national in scope and provide a basis for HCFA programmatic decision making. The number of reviews performed will be reduced. In addition, greater reliance on automated systems, including personal computers, will eliminate the need for some statistical and clerical support.

It should be noted that the foregoing discussion was focused on the BQC. While this plan will achieve Central Office savings, it should also be noted that Regional Office savings will occur. For every FTE saved in the Central Office another two will be saved in the Regional Offices.

Inability to Meet Current Ceiling

While we have laid the groundwork for how HCFA will look in the future, our overall employment level is being reduced only at the rate of attrition. This attrition level will not allow us to achieve either our FY 1985 ceiling of 3,980 or our FY 1986 ceiling of 3,300.

(1) FY 1985

At the beginning of FY 1985, HCFA's FTE employment was approximately 4,000. We continued hiring when we received the Department's October 30, 1984, memorandum advising HCFA that its ceiling for FY 1985 was 4,068. Consequently, our FTE employment had climbed to 4,015 by December 1984 when we received the final ceiling of 3,980. This level, however, did not include:

a. the employees necessary to perform the "look-behind" surveys of intermediate care facilities for the mentally retarded (ICFs/MR) that were mandated by Congress in the Appropriations Bill; or

b. employees who had not yet entered-on-duty but to whom we had made firm job commitments. These employees were in critical positions, primarily in the Regional Offices, that became vacant during the FY 1984 hiring freeze.

In January, HCFA instituted a freeze on hiring from outside HCFA and the Administrator directed each Associate Administrator to take strong management action in this regard. Our "on-board" strength in FTE terms is now 4,067 and includes most of the employees mentioned above.

Also of concern is the fact that attrition seems to be slowing down. While in the past, HCFA has averaged an attrition rate of approximately 22 per month, it appears that a conservative estimate of 20 per month may be more appropriate. It should be noted, however, that during the last 3 months, attrition has averaged 16 per month. Assuming an attrition rate of 20 per month and no hiring for the remainder of the year, we estimate our FTE consumption will be 4,041.

Date	Losses	Gains	On-Board (FTE)	FTE Consumption
05/30/85	---	---	4,067	--
09/30/85	71	---	3,996	4,041

(2). FY 1986

If we continue the same assumptions (i.e., no further hiring and an attrition level of 20 per month for all of FY 1986) our FTE consumption would be 3,876. This can be seen as follows:

Date	Losses	Gains	On-Board (FTE)	FTE Consumption
09/30/85	---	---	3,996	--
09/30/86	240	---	3,756	3,876

Ability to Operate on a Policy of Attrition

The foregoing scenario assumes that HCFA can successfully manage its programs by allowing attrition to occur and not hiring anyone from outside HCFA through FY 1986. Clearly this is not reasonable in that attrition will occur relatively proportionately across both high and low priority areas.

In order to assess the impact of this phenomenon, we analyzed the position classification of those employees who left the Agency over a 4 month period from January through April 1985. During this period a total of 90 people left the Agency. Thirty-four were clerical and 25 of these were clerk-typists and secretaries. The remainder were professional and at a minimum 20 should be considered high priority. Few occurred in those functions that the Agency targeted for reduction. The listing is attached.

As a result, we have concluded that in order to manage a program as complex as HCFA's, some allowance must be made to replace key people during the period of downsizing.

FY 1987 Target

The target level for HCFA that was provided in the February 15 letter from the Director, Office of Management and Budget, was 3,652. This target level appears to assume that HCFA would end FY 1986 with an end-of-year employment level of 3,652 and the FY 1987 FTE level was set accordingly.

As noted in the foregoing, however, HCFA's end-of-year employment level would be 3,756 assuming that a policy of complete attrition is followed in FY 1986. In order to achieve an FTE consumption level of 3,652, HCFA would have to continue some hiring restrictions in FY 1987 and would have to reduce employment strength to 3,548. This can be seen as follows:

Date	Losses	Gains	On-Board (FTE)	FTE Consumption
09/30/86	---	---	3,756	---
09/30/87	240	32	3,548	3,652

HCFA has undertaken a preliminary assessment of making further reductions to achieve the FY 1987 target. Reductions of this magnitude would result in the elimination of key functions given the magnitude of reductions that have been taken in the past. These further reductions would seriously compromise the ability of the Agency to perform its mission. Furthermore, it should be noted that there are only two ways to organizationally achieve this reduction: (1) a RIF which is totally disruptive to the Agency and would affect an average of five other people for each targeted position, or (2) a policy of attrition which would be equally disruptive as attrition would occur in both high and low priority programs. To continue a policy of attrition into FY 1987 would be devastating to the Agency.

Relationship to other DHHS Programs

A comparison was made of the FTE status for DHHS components over time. This table is attached. This table displays those Agencies with FTE reductions between 1981-1986 which are over and under 20 percent. When examining the grouping of Agencies with reductions greater than 20 percent, it is striking that HCFA is the only Agency that has had major program increases while the other OPDIVs have had major program decreases.

The following examples illustrate some of the programmatic changes that have occurred in the other Agencies that have sustained FTE reductions greater than 20 percent.

Office of Community Services (OCS)

- OCS is currently in a phase-out status, and is expected to be eliminated in FY 1987.

Health Resources and Services Administration (HRSA)

- The conversion of categorical programs such as Maternal and Child Health and Primary Care to block grants reduced the administrative workload at the Federal level.
- The phase-down and phase-out of the Health Planning, Facilities, and HMO programs reduced workload.
- The closure of Public Health Service hospitals and clinics resulted in FTE reductions of over 5,400 by eliminating a complete function.

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)

- The conversion of categorical programs such as Drug Abuse and Alcoholism Centers and Mental Health Centers into a block grant format reduced administrative workload at the Federal level.
- The transfer of St. Elizabeth's Hospital to the District of Columbia eliminated a function.

Office of Human Development Services (OHDS)

- In 1981 Title XX of the Social Security Act was put into block grant format reducing administrative workload at the Federal level.

Office of the Secretary (OS) and Office of the Assistant Secretary for Health (OASH)

- OS and OASH has experienced FTE reductions as part of the President's initiative to streamline management and decrease administrative overhead in Federal agencies.

Health Care Financing Administration (HCFA)

- As evident from this discussion, the other OPDIVs in the Department, while experiencing a comparable decrease in their FTE level, have primarily had decreases in their programs and/or scope of responsibility. In contrast, HCFA has implemented four major legislative initiatives:
  - Omnibus Reconciliation Act of 1980 and 1981
  - Tax Equity and Fiscal Responsibility Act of 1982
  - The Social Security Amendments of 1983
  - Deficit Reduction Act of 1984

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  - Omnibus Reconciliation Act of 1980 and 1981
  - Tax Equity and Fiscal Responsibility Act of 1982
  - The Social Security Amendments of 1983
  - Deficit Reduction Act of 1984

- Although these and other provisions have imposed additional complex requirements, no new positions have been requested to handle the sizeable increase in program responsibility. The full implementation of TEFRA alone would have required approximately 250 more FTEs.
- Clearly, HCFA is more appropriately grouped with the set of agencies whose ceilings have been reduced less than 20 percent. Like those agencies the role of HCFA has remained fundamentally unchanged throughout this Administration.

HCFA 1986/87 Proposal

As a result of its analysis HCFA has reached the following conclusions:

1. An FTE level below 3,800 would have severe consequences for the Agency. The reductions that will have occurred are significant. The further reductions that would have to occur to reach the FY 1987 OMB target would be damaging to the Agency and prevent it from meeting its program objectives.
2. In reaching the goal of 3,800 FTEs, some allowance has to be made to replace key losses. A policy of attrition does not allow the agency to maintain the cadre of key individuals that are necessary for the organization to function effectively.
3. In setting FTE ceilings, top management must focus equally on employment levels. In downsizing an organization, the on-board employment level must be reduced below the FTE ceiling level in order to achieve it.
4. HCFA's FTE ceiling has already been reduced disproportionately compared with other programs whose mission has not been fundamentally changed during this Administration.

Based on these conclusions, HCFA proposes to:

- Continue to freeze employment through the remainder of FY 1985 in order to minimize its FTE consumption for the remainder of that year. Based on an assumed attrition rate of 20 per month, FY 1985 FTE consumption would be approximately 4,041.
- HCFA proposes to defer the target level of 3,800 from FY 1986 to FY 1987. This would allow HCFA to establish a policy of filling key positions which become vacant through attrition. The FY 1986 request of 3,935 FTEs would allow a replacement of one position for every two vacancies. This would provide an orderly transition to the goal of 3,800 FTEs without the disruption caused by a policy of complete attrition.

LOSSES BY COMPONENT

January through April, 1985

BUREAU/OFFICE Series-Title	Grade	CLERICAL Priority	 Other	 Subtotal	PROFESSIONAL Priority	 Other	 Subtotal	TOTAL
DAA								
986-Legal Clerk (typ)	GS-5	-	1	1	-	-	0	1
950-Paralegal Spec.	GS-5	-	-	0	-	1	1	1
Subtotal		0	1	1	0	1	1	2
TOTAL DAA		0	1	1	0	1	1	2
AAMSS								
OMB								
303-Med Grp Prem Tech	GS-6	-	1	1	-	-	0	1
356-Data Trans	GS-4	-	1	1	-	-	0	1
203-Pers Asst	GS-6	-	1	1	-	-	0	1
343-Mgmt Analyst	GS-7/11	-	-	0	-	2	2	2
235-Empl Dev Spec	GS-12	-	-	0	-	1	1	1
3502-Laborer	WG-03	-	1	1	-	-	0	1
1102-Contract Spec	GS-13	-	-	0	1	-	1	1
6907-Whouse Wkr	WG-05	-	1	1	-	-	0	1
318-Secretary	GS-5	1	-	1	-	-	0	1
Subtotal		1	5	6	1	3	4	10
ODMS								
303-Tech Recds Exam	GS-6	-	1	1	-	-	0	1
345-Prog Analyst	GS-9	-	-	0	-	1	1	1
334-Computer Prog	GS-12	-	-	0	-	1	1	1
334-Computer Prog	GS-14	-	-	0	-	3	3	3
101-Soc Sci Res Anly	GS-15	-	-	0	-	1	1	1
Subtotal		0	1	1	0	6	6	7
OACT								
1530-Statistician	GM-14	-	-	0	1	-	1	1
1530-Actuary	GS-11	-	-	0	1	-	1	1
1530-Actuary	GS-9	-	-	0	2	-	2	2
Subtotal		0	0	0	4	0	4	4

EOO								
							0	0
318-Secretary	GS-5	1	-	1	-	-	0	1
Subtotal		1	0	1	0	0	0	1
TOTAL AAMSS		2	6	8	5	9	14	22
AAP								
IDAAP								
340-Assoc Admin	ES	-	-	0	-	1	1	1
Subtotal		0	0	0	0	1	1	1
BERC								
318-Secretary	GS-5	3	-	3	-	-	0	3
318-Secretary	GS-6	-	-	0	-	-	0	0
345-Prog Analyst	GS-13	-	-	0	-	2	2	2
303-Corr Cont Clerk	GS-5	-	1	1	-	-	0	1
322-Clerk Typ	GS-3	1	-	1	-	-	0	1
Subtotal		4	1	5	0	2	2	7
ORD								
345-Prog Analyst	GS-13	-	-	0	1	-	1	1
Subtotal		0	0	0	1	0	1	1
OLP								
950-Legis Anlyst	GS-12	-	-	0	-	1	1	1
101-Office Dir	ES	-	-	0	1	-	1	1
101-Soc Sci Res Anly	CC	-	-	0	-	1	1	1
Subtotal		0	0	0	1	2	3	3
TOTAL AAP		4	1	5	2	5	7	12

AAO								
BPO								
345 Supv Prog Anly	GM-14	-	-	0	-	1	1	1
1102-Supv Contr Spec	GM-14	-	-	0	-	1	1	1
318-Secretary	GS-5	1	-	1	-	-	0	1
Subtotal		1	0	1	0	2	2	3
BOC								
318-Secretary	GS-5	2	-	2	-	-	0	2
345-Program Anly	GS-9	-	-	0	-	1	1	1
345-Program Anly	GS-12	-	-	0	-	1	1	1
Subtotal		2	0	2	0	2	2	4
HSQB								
318-Secretary	GS-5	1	-	1	-	-	0	1
345-Program Anly	GS-11	-	-	0	-	1	1	1
Subtotal		1	0	1	0	1	1	2
TOTAL AAO/CO		4	0	4	0	5	5	9
REGIONS								
334-Computer Reqs Anly	GS-12/13	-	-	0	2	-	2	2
510-Accountant	GS-12/13	-	-	0	4	-	4	4
501 Contr Budg Spec	GS-11/12/	-	-	0	-	4	4	4
301 Med Policy Spec	GS-12/15	-	-	0	-	9	9	9
301-Prepaid Hlth Contr	GS-13	-	-	0	1	-	1	1
610-Nurse Cons	CC	-	-	0	2	-	2	2
610-Nurse Cons	GS-12	-	-	0	1	-	1	1
318-Secretary	GS-5/6	8	-	8	-	-	0	8
322-Clerk Typ	GS-2/3/4	7	-	7	-	-	0	7
660-Hosp Admin	CC	-	-	0	1	-	1	1
345-Prog Anlyst	GS-9/12	-	-	0	-	3	3	3
303-Clerk	GS-3	-	1	1	-	-	0	1
602-Medical Adv	CC	-	-	0	1	-	1	1
669-Medical Rcds Adm	CC	-	-	0	1	-	1	1
Subtotal		15	1	16	13	16	29	45
TOTAL REGIONS		15	1	16	13	16	29	45
TOTAL, HCFA		25	9	34	20	36	56	90

DHHS FULL TIME EQUIVALENT

	1981	1982	1983	1984	1985	1986	1987	% Change	% Change	% Change Actual Planning Ceiling
Agencies With Reductions Greater Than 20%										
OCS	--	179	162	59	51	36	--	-72*	-89*	-100*
HRSA	10,996	5,359	4,738	4,008	3,516	2,631	1,724	-68	-76	-84
OASH	2,082	1,675	1,600	1,547	1,436	1,356	1,245	-31	-34	-40
ADAMHA	2,216	1,624	1,660	1,643	1,527	1,480	1,440	-31	-33	-35
OHDS	1,696	1,430	1,351	1,306	1,210	1,151	1,050	-29	-32	-38
OS	5,583	5,176	5,483	4,787	4,231	4,131	3,980	-24	-26	-29
ST. Elizabeth's	4,014	3,768	3,859	1,757	--	--	--	--	--	--
HCFA	4,857	4,496	4,090	4,055	3,960	3,800	3,652	-18	-22	-25
Agencies With Reductions Less Than 20%										
NIH	12,633	12,691	13,415	13,662	13,107	12,957	12,700	+3.7	+2.5	+.5
IHS	11,010	10,283	10,309	11,035	11,218	11,047	10,850	+1.9	+.3	-1.5
CDC	4,279	3,956	3,996	4,198	4,178	4,128	4,000	-2.4	-3.5	-6.5
SSA**	81,196	83,595	83,759	81,655	79,733	77,935	74,778	-2.0	-4.0	-6.0
FDA	7,803	7,315	7,293	7,257	7,195	7,094	6,914	-7.8	-9.1	-11.4

* %Change For 1982
** Includes ORR

HEALTH CARE FINANCING ADMINISTRATION
ADMINISTRATIVE COSTS

Summary of Changes

FY 1986 President's Request	$204,600
Add:	
Proposed Supplemental Request	12,821
Revised FY 1986 Budget	217,421
Add:	
Built-in Increases:	
One Additional Day	612
Employee Within-Grades	1,577
Telecommunications	439
Postage	217
Space Rental	768
Inflation	1,726
Subtotal	5,339
Program Increases:	
Telephone Switching System	3,000
Automated Data Processing	850
PRISM	4,560
Subtotal	8,410
Reductions:	
135 FTEs	(5,484)
Support contracts associated with the reduction of 135 FTEs	(1,774)
Subtotal	(7,258)
Total FY 1987 Request (Obligations)	$223,912
Proposed Multi-year funding	34,100
Total FY 1987 Program Level	$258,012

FUNCTIONAL HIGHLIGHTS AND ACCOMPLISHMENTS

1. PROGRAM ADMINISTRATION

This function, much of which is mandated by law, encompasses an assortment of responsibilities involved in the administration of the Medicare program and oversight of the Medicaid program. Specific activities include:

Medicare

- Development, negotiation, maintenance and modification of primary contracts with intermediaries and carriers, including those awarded on an experimental basis.
- Monitoring and evaluation of Medicare contractors' performance in carrying out statutory and contractual responsibilities.
- Development and maintenance of a comprehensive program to contract with and make payments to Group Health Plans and Health Maintenance Organizations for provision of services.
- Review of provider requests for exceptions to reimbursement limits (e.g., Section 223 cost limits, End Stage Renal Disease (ESRD) composite rates).
- Proceedings of the Provider Reimbursement Review Board (PRRB) which reviews appeals submitted by Medicare providers under Section 1878 of the Social Security Act.
- Review of PRRB decisions by the Attorney Advisor to: (1) ensure compliance with all applicable laws, regulations and policy issues; and (2) recommend decisions under "own motion" review.
- Administer subcontracting initiatives with small and disadvantaged businesses to enhance competition in subcontracting.

Medicaid

- Review and approval of State Medicaid Plans to ensure compliance with Federal laws and statutes.
- Review and evaluation of each State's administration of Medical responsibilities.
- Identification of deficiencies in State Medicaid Plans so that corrective action can be taken.
- Review of requests for State Medicaid Plan amendments and waivers of certain program requirements in order to help States gain greater flexibility in administering the Medicaid program.

Major Highlights/Significant Accomplishments

- Prepared and released GROUPER changes to recalculate DRG weights. Awarded contract to maintain GROUPER. Issued three updates to the PRICER package and prepared a fourth.
- In FY 1985, HCFA expects to execute 98 Medicare contractor agreements.
- Because prospective reimbursement under risk sharing with HMOs became operational in FY 1985, it is anticipated that Medicare enrollees in the HMO plans will increase by 40 percent.
- In FY 1985, the PRRB will conduct over 175 hearings/prehearings and render over 180 decisions; the Attorney Advisor conducts final Agency review of all PRRB decisions and will also prepare about 120 court actions.
- In FY 1985, HCFA will process about 500 State plan amendment requests, 350 waiver and waiver modification requests, and review 18 decisions resulting from State Medicaid plan amendment reconsideration hearings.
- In FY 1985, HCFA will process approximately 400 provider exception requests including about 100 ESRD exception requests.
- In FY 1985, HCFA will conduct comprehensive performance evaluations of about 50 State Medicaid agencies and 120 Medicare contractors.
- Sections of the Deficit Reduction Act of 1984 are being implemented which required that clinical diagnostic laboratory services performed by independent clinical laboratories, physician offices, and hospitals be reimbursed under a fee schedule; and required the establishment of a registry to monitor pacemakers.
- The Prospective Payment System (PPS) for Medicare hospital services was implemented on October 1, 1983. In FY 1985, HCFA revised instructions to cover changes contained in the Deficit Reduction Act of 1984 and refinements gained through experience.
- Changes in reimbursement for laboratory services were implemented on July 1, 1984. A fee schedule is used for reimbursing laboratory services performed by physicians, independent laboratories, and hospital outpatient departments. In addition, independent laboratories must bill the Medicare program directly and accept assignment; there is no deductible for coinsurance for independent or hospital outpatient laboratory services.
- A participation program was implemented on October 1, 1984. Physicians and suppliers who participate agree to accept assignment in all cases. HCFA is also implementing a program to monitor changes of non-participating physicians; non-participating physicians are prohibited from raising fees during a 15-month period beginning July 1, 1984.

- HCFA arranged for the transfer of 1,100 providers from the Office of Direct Reimbursement (ODR) to other contractors and reassigned the ODR employees throughout HCFA to best utilize their extensive operational experience.

FY 1986/1987 Initiatives

- Conduct a demonstration project with three ROs to run concurrently with the ongoing Part B Quality Assurance (QA) program. The design will focus on the identification of high-dollar, high-risk situations. If appropriate, Part B QA emphasis will shift to in-depth reviews in national and regional problematic areas in FY 1987.
- Conduct denova study to validate the accuracy of Part B error rate data in FY 1986.
- Evaluate carrier/intermediary performance in identifying and processing claims/bills with potential Medicare Secondary Payor (MSP) involvement. If appropriate, design and implement evaluative program for MSP for Part A and Part B. This effort will complement and bolster HCFA's initiatives to assure MSP payment integrity.
- Redesign Medicaid Eligibility Quality Control (MEQC) system to provide targeting of resources on error-prone areas.
- Redesign Utilization Control (UC) program to provide an increased emphasis on quality care of long-term-stay patients.
- In FY 1986, a PPS Settlement Review program is scheduled for implementation and will evaluate the adequacy of contractor's first year PPS settlement and audit activity.
- Planned for FY 1987 is a comprehensive review program to monitor the audit and settlement activity of small Medicare providers; e.g., SNFs, CORFs, OPPTs, QSCs, etc.

2. MEDICARE/MEDICAID FINANCIAL OPERATIONS

HCFA oversees the financial mechanisms in the Medicare/Medicaid programs in order to identify and curtail waste and abuse. Specific activities include:

- Preparation of the national budget to finance Medicare contractor activities; review and approval of individual contractor budgets and budget amendments.
- Monitoring of each Medicare contractor's financial operations, including review of expenditure plans, interim expenditure reports, final administrative cost proposals, banking agreements, subcontracts and leases.
- Ongoing review of each State's Medicaid operations, including quarterly budget forecasts and quarterly expenditure reports.

- Review of Medicare contractor and State Medicaid Agency implementation of institutional reimbursement policies to assure that providers claim only the proper amount for services rendered.

- Coordination of the clearance and resolution process for Office of the Inspector General Audit Agency (OIGAA) audits of Medicare intermediaries, carriers, State Medicaid Agencies, State Survey Agencies, Professional Standards Review Organization (PSROs)/Peer Review Organizations (PROs), and ESRD networks.

- Development of statistics/estimates on administrative costs of Medicare contractor/State Medicaid Agency operations.

- Monitor contractor audit performance (audit costs and recoveries) to maximize the effectiveness of audit funds invested. Maintained an ongoing return of $5 for each $1 spent on provider audit.

- Conduct of disallowance activities resulting from external audits, HCFA audits, Medicaid Eligibility Quality Control, utilization review, and section 1122 denials.

- Monitoring of Medicare contractor/State Medicaid Agency activities in the areas of overpayment identification and recovery; and the processing of uncollectable overpayments, all beneficiary overpayments, and reconsideration claims and hearings.

Major Highlights/Significant Accomplishments

- In FY 1985, HCFA implemented the Program Administration to Reduce Overpayments & Losses (PATROL) project designed to isolate causes of significant program dollar losses in Medicare and Medicaid and stimulate the policy and procedural changes needed to reduce these losses.

Medicare

- It is anticipated that FY 1985 overpayment recoveries will be approximately $1.2 billion. (In FY 1984, interest on Part A and B overpayments was assessed, HCFA assessed $9.7 million in interest of which $8.9 million (92 percent) was collected.)

- In FY 1985, HCFA will process about 2,843 contractor financial documents including intermediary and carrier budgets and cost reports for the Medicare program.

- In FY 1985, HCFA will continue to increase emphasis on reducing Medicare contractor costs by closely analyzing those with high costs, implementing cost/burden reduction initiatives and upgrading EDP systems.

- In FY 1985, HCFA will continue to increase emphasis on the payment safeguard activities of Medicare contractors (medical/utilization review and provider audit) to insure comprehensive oversight of benefit amounts paid and maximization of savings.

- During FY 1983, HCFA developed prescriptive audit protocols to address major areas which should be reviewed in all base period audits. The success of this effort has been demonstrated by the cost-effectiveness of our base period audits (in excess of 11 to 1). Therefore, we will develop and provide more prescriptive audit guides for TEFRA and PPS audits to be applied in FY 1985 and FY 1986.
- In FY 1985, HCFA will process about 16,000 uncollectable beneficiary overpayments and identify 35,000 Medicare provider/supplier overpayments.
- In FY 1985, HCFA converted the first of the Medicare contractor workload reports to a system of direct electronic input from Medicare contractors.

Medicaid

- In FY 1985, HCFA will review about 548 Medicaid budget and expenditure reports.
- Every quarter, Medicaid grant awards are prepared and issued to 57 States and territories. Each grant award provides funding for the current quarter, and applies all adjustments applicable to the last quarter. Separate grant awards are issued to reflect various types of reductions.
- HCFA will continue efforts, started in FY 1984, for automating the Medicaid grants/expenditures data. Automation will greatly facilitate tracking and control over obligations and various types of reductions.
- HCFA has prepared and issued to its regional offices a series of Medicaid financial review guides which, in each instance, lay out the pertinent law, regulations and policy, and provide detailed financial audit steps to be followed in reviewing State reimbursement claims.
- During FY 1985, HCFA will issue about 99 disallowances totaling $308m.
- HCFA plans to release 43 multi-OPDIV requests involving FFP to the States for title XIX MMIS.
- HCFA will comment on about 30 regional office approval/disapproval matters involving title XIX FFP.

External Audits

- During 1985, approximately 264 audits with recommended disallowances of approximately $141.3 million will be processed.

3. MEDICARE/MEDICAID AGENT PERFORMANCE ASSESSMENT

The assessment of Medicare and Medicaid program agent performance provides for financial and programmatic accountability in these two programs; results in the identification and resolution of specific problem areas; and improves program efficiency through the reduction of erroneous program payments. Specific activities include:

- Performance evaluations of the Medicare contractors and State Medicaid Agencies and the publication of results of these evaluations which are used to identify erroneous payments trends, develop corrective action strategies, and identify exemplary practices.
- Recommendations of (1) renewal or termination of individual Medicare contractors; and (2) sanctions or adverse actions against State Medicaid Agencies or Medicare fiscal agents resulting from failure to meet performance criteria in various operational areas.
- Evaluation of Medicare contractor and State Medicaid Agency programmatic ADP systems.
- Identification of program policies and instructions that require clarification or modification.

Major Highlights/Significant Accomplishments

Medicare

- Instructions for preparation of Annual Contractor Evaluation Reports (ACER) were modified to assure that these reports thoroughly highlighted significant performance areas and would be the basic document for contract management decisions.
- In FY 1985, HCFA will review over 8,876 performance elements in the operations of Medicare contractors and issue 121 Annual Contractor Evaluation Reports (ACERs).

Medicaid

- In FY 1985, approximately 90 reports on payments under approved Home and Community-Based (HCB) waivers will be reviewed and analyzed to determine if each waiver is cost effective as required.
- In FY 1985, HCFA will review over 500 State performance areas and issue 51 State Medicaid Operations Reports (SMORs).
- In FY 1985, HCFA will review the implementation of approximately 40 approved HCB waivers.

- In FY 1985 data validation reviews have been performed in 4 States in addition to 44 States reviewed in FY 1984.
- In FY 1985, a special study of payments to Intermediate Care Facility (ICF)/Medical Review (MR) will be completed focusing on the propriety and accuracy of payments in seven targeted States. Over 1,100 cost reports are being reviewed and analyzed in the project.

4. QUALITY CONTROL

The primary objective of this function is to maintain the fiscal integrity of the Medicare and Medicaid programs and enforce health and safety standards. Specific activities include:

- Oversight of Medicare intermediary activities for both retrospective and prospective based providers including audits, settlements, interim payments, and rate determinations.
- Evaluation of samples of Medicare Part B claims to assess Medicare carrier performance.
- Reviews of State Medicaid determinations in the areas of reimbursement, eligibility, third party liability, and claims processing.
- Monitoring of the medical and utilization review activities of Medicare contractors, State Medicaid Agencies and Peer Review Organizations (PROs).

Major Highlights/Significant Accomplishments

Medicare

- In FY 1985, HCFA implemented the Quality Evaluation of Settlements under TEFRA (QUEST) and the Home Office Quality Evaluation of Settlements under TEFRA (HO-QUEST) to monitor and evaluate contractor operations involving TEFRA audits.
- During FY 1985, HCFA evaluated and monitored the audits conducted in the 4 waiver States - New York, Massachusetts, Maryland, and New Jersey. These audits established both base year data and the hospital specific rate for providers in the event that States terminated demonstrations and/or did not apply/receive an 1886(c) waiver.
- During FY 1985, HCFA will participate in the oversight efforts of the hospice audits and rate setting calculations.

- During FY 1985, a pilot review to evaluate the accuracy of FI processing of PPS inpatient bills is being conducted. Results from this review will determine the necessity for an ongoing national evaluation program.

- During FY 1985 a study is being conducted to obtain data on the accuracy in preparation of both EMC and Hard Copy claims. Study data may result in program or operational revisions to assure continuing accuracy of Part B claim preparation.

- During FY 1985, HCFA initiated RO/CO workgroup and established an ad hoc TAG for the Part B QA redesign. In addition to meetings held, a national User's Survey was developed to solicit input for the upgrading and redesign of management report outputs from ROs and carriers. Efforts will result in improved management data to better evaluate claims processing by Part B carriers.

Peer Review Organizations

- HCFA has issued five PRO program directives and three Interim Manual Issuances.

- During the period FY 1985-1986, HCFA will work closely with individual PROs to ensure successful implementation of the PPS and enforce standards of health and safety in the delivery of hospital care, and will continue to do so in FY 1986.

- During FY 1985, HCFA has reviewed/evaluated 28 PRO proposals; conducted 24 PRO contract negotiation sessions; held 34 PRO contract debriefings; resolved two contract protest actions; awarded 22 PRO contracts; and renegotiated in all 54 PRO areas.

- HCFA has processed 75 severance pay grant actions to close out the PRO program. Ten grant appeals on severance pay are pending.

- HCFA processed 149 PSRO grants actions.

- HCFA reviewed 98 audits and 187 budgets.

- By November 9, 1984, all PRO contracts became operational. In March 1985 HCFA notified the Pennsylvania PRO of the intent to terminate.

- In FY 1985, all carriers implemented 7 electronic prepayment screens with set parameters to assure national consistency/uniformity. During the same fiscal year, 13 additional screens with parameters were pilot tested at 22 carrier sites. As a result of these pilot tests, use of an additional set of screens will be mandated in FY 1986.

- In FY 1985, carriers began profiling physician practice patterns to determine whether there were any changes in response to the physician fee freeze (for example, increase in services, upcoding, increase in mix of services). Corrective action will be taken if necessary.

- In FY 1985, an A-B link was established whereby intermediaries notify carriers of inpatient hospital or SNF denials. The carriers then review claims for associated physician services to determine whether they were medically necessary.

- In FY 1986, HCFA will make any necessary adaptations or modifications to the medical review process in response to Congressional mandate.

- In FY 1985, as part of the emphasis on home health services, HCFA revised the coverage compliance review procedures to require postpayment onsite audits. This enables the FI medical staff to verify that claims were correctly paid.

- In FY 1985, HCFA also developed home health plan of treatment/patient information forms to be used by FIs in reviewing home health claims. These forms result in uniform data collection and more accurate coverage decisions. Training sessions were conducted for all FIs on home health coverage and how to use the new forms. FIs were also provided with training packages for use in instructing providers on the new forms.

- In FY 1985, FIs began implementing outpatient physical therapy prepayment screens and increased CORF claim review to 100 percent.

- Quality review continues to be an important part of the PRO program. PRO milestones are and will continue to be evaluated to determine the extent to which PROs achieve their quality objectives.

- The areas subject to PRO review are expanding. PROs are increasing their monitoring of readmissions and transfers, HMO review policies are being developed, and the development of outpatient surgical review policies for use by PROs is being considered.

Medicaid

- In FY 1985, the State Performance Evaluation and Comprehensive Test of Reimbursement under Medicaid (SPECTRUM) program replaced the Systems Test for Alternative Reimbursement (STAR) and the Institutional Reimbursement section of the State Assessment program. SPECTRUM will be conducted in 50 states and like STAR will evaluate the State's action in setting, adjusting, and monitoring Medicaid institutional reimbursement.

- In FY 1985, under the Medicaid Eligibility Quality Control Program, HCFA will complete over 25,000 eligibility reviews.

- In FY 1985, $3.2 million will be withheld from States based on TEFRA projections.

- In January 1985, States were notified of TEFRA disallowances for the April and July quarters of FY 1983 totalling $24.8 million and Michel Amendment disallowances for FY 1982 totalling $40.6 million.

- In FY 1984 and FY 1985 State agencies were monitored to assure they met the requirements of the (UC) program. In FY 1985, $12 million in penalties was assessed for 33 States.

- In FY 1985, HCFA will conduct a series of 10 pilot audits of Third-Party Liability (TPL) operations. The audits are focused on trauma diagnoses codes, Aid to Families with Dependent Children (AFDC) medically needy cases, hospital intake records and use of TPL indicators.

- HCFA is participating in a joint project with SSA whereby SSA will collect detailed TPL resource information from SSI applicants/recipients during initial intake and redetermination processes. SSA will provide these TPL collection procedures to all interested section 1634 States, i.e., those where SSA makes a simultaneous determination of Medicaid eligibility when making a determination of eligibility for SSI benefits. As of May 1985, SSA had implemented the TPL recovery procedure in 18 of 32 section 1634 States.

- HCFA has implemented a Nursing Home Reporting System in 4 States. This system allows the States to detect unnecessary or improperly billed services to Medicaid patients in Nursing Homes.

5. OPERATIONAL REVIEW ACTIVITY

HCFA has primary responsibility for operational reviews which assess the need for policy and operational reforms in vulnerable program areas. Specific activities include:

- Preparation of pilot studies of selected program and policy issues through the review of in-house information, supplemented by additional on-site documentation, to determine whether national reviews should be undertaken.

- Development of detailed review guides, manual instructions, quarterly reports, summary issue papers, and special studies.

Major Highlights/Significant Accomplishments

- Reviews in FYs 1984 and 1985 have focused on the following areas:

- Medicare Secondary Payor (An initial review in FY 84 focused on the ability of hospitals to identify MSP occurrences and the degree to which they were billing primary issuances where Medicare was the secondary payor. A followup review in 1985 is looking at the effectiveness of a number of new MSP initiatives and the validity of actuarial projections on MSP savings, particularly with respect to new DEFRA legislation.)

- HCFA's State Review and Evaluation Programs

- Parenteral/Enteral Therapies

- Part B Medical Review/Utilization Review

- Pacemaker Reimplantation

- HHA National Review (The major findings of this review were: 1) Based on an independent review by HCFA nurse panel over 1/3 (34%) of all home health care billed to Medicare in 1984 was for noncovered services and represented approximately $600 million whereas intermediaries denied less than 3% of home health services billed that year; 2) Though there has been a dramatic growth in the number of HHAs, particularly proprietary or for profit agencies, there has not been a dramatic increase in the hospital discharge to HHAs or the number of HHA services provided to beneficiaries since PPS; 3) HCFA's Coverage Compliance Review Program (CCRP) figures look behind compliance initiative performed by intermediaries results in higher denial rates than the normal claims processing utilization systems used by intermediaries; 4) The major cause of the low intermediary/denial rate was the inadequacy of medical information submitted on or with HH claims.

- Medicaid Oversight Program

- Medicare Oversight Program

- Providers Base Physician (PBP)

- Cardiac Pacemaker (Physician Fees)

- Cardiac Rehabilitation Centers

- Peer Review Organization (PRO) Data

- Malpractice

- Medicare Secondary Payor (MSP) (Spousal ESRD, HMO)

- Medical technologies

- Prospective Payment System (PPS) Discharges

- Beneficiary Profiling System (utilization and expenditure changes under PPS)

- o In FY 1986 and 1987, operational reviews will address at least a dozen issues of concern to HCFA managers including:
    - Laboratory Fee Schedules
    - Ambulatory Surgical Centers
    - ESRD Composite Rates
    - Hospice Care
    - Health Maintenance Organizations (HMOs)
    - Physician Reimbursement
    - The reconciliation of State ICF/MR reimbursement and cost report analysis in seven States as part of HCFA's "Look Behind" effort with respect to ICF/MRs.
- o Review in 1985
    - Beneficiary Profiling System Utilization and Expenditure Changes under PPS.
- o In FY 1985, operational reviews will address the following issues:
    - Transfers and Unbundling under PPS
    - HCFA's Medicare and Medicaid Contractor Oversight Programs

6. MAINTENANCE OF HEALTH AND SAFETY STANDARDS

HCFA is responsible for the establishment and implementation of the statutory Federal health and safety standards which stipulate specific structural requirements as well as quality of care conditions for approximately 44,000 Medicare and Medicaid facilities. Specific activities include:

- o Development, analysis, and enforcement of standards for all providers and suppliers participating in the Medicare/Medicaid program.
- o Evaluation of the performance of State Survey Agencies.
- o Conduct of Federal validation surveys.

Major Highlights/Significant Accomplishments

- o HCFA has developed an ESRD facility based quality assurance program to improve the quality of care provided to ESRD patients.
- o Improvements have been made to the effectiveness, accessibility and reliability of the Medicare/Medicaid Automated Certification System (MMACS) by (1) strengthening the computer link between States and HCFA; and (2) simplifying resurvey scheduling.

- HCFA has encouraged States to integrate the Inspection of Care review process with the survey process in LTC facilities. This will eliminate the dual review process and provide more efficient use of resources.
- Survey procedures and training programs have been developed for hospices.
- HCFA has developed outcome-oriented survey tools to improve the quality assurance aspects of the survey process.
- Experiments have been conducted to improve the efficiency of the survey process.
- HCFA has identified problems in public institutions for the mentally retarded and will implement Federal enforcement actions as required.
- Between 1984 and 1987, 5,562 additional health care providers will be surveyed and added to the Medicare and Medicaid programs. Beneficiaries will have access to additional health care services due to newly authorized facility types, e.g., ambulatory surgical centers, comprehensive outpatient rehabilitation facilities and hospices.
- During FY 1985, 37 State surveyor training courses will be conducted for about 1,700 surveyors as part of the oversight and support of 2,800 surveyors nationwide.
- "Look-behind" surveys of Intermediate Care Facilities for the Mentally Retarded will be conducted in FY 1985 with the additional funds and positions provided by Congress. These surveys ensure that providers meet standards of participation for Medicaid.
- In FY 1985, HCFA plans to make over 108 State Agency Evaluation Program (SAEP) visits and issue 45 Comprehensive Evaluation Reports (CERs) on State Survey Agencies.
- HCFA has expanded the survey process for home health agencies to include home visits. These home visits will ensure that home health agencies comply with program requirements concerning the delivery of patient care services.
- HCFA is working towards national implementation of intermediate sanctions to deny Medicare payments for new admissions to long term care facilities in lieu of termination, if it is determined that the facility does not meet one or more conditions of participation and the facility's deficiencies pose no immediate jeopardy to patients' health and safety.

- Regional staff and a panel of psychiatric consultants will be used to increase survey coverage of the two special conditions in psychiatric hospitals.

7. REGULATIONS DEVELOPMENT

Regulations are the vehicle for implementing legislative actions and Administration initiatives. In the current thrust toward streamlining reporting requirements and reducing program costs, the regulations development and review process plays a key role. In the conduct of this function, HCFA staff develop, review and clear regulations, manual instructions, guidelines, and other policy documents.

Major Highlights/Significant Accomplishments

- In FY 1985, HCFA staff will prepare approximately 150 regulation documents. Major initiatives include the Prospective Payment System regulations and various budget items; e.g. direct Medicare education costs and Part B payment for non-physician services. Other regulations are likely to result from legislative proposals.
- The final rule on area designation in the Peer Review Organization program was published in April 1984. The final HMO rule was published in January 1985.
- During FY 1985, notice of three new HCFA systems requirements for the Medicaid Management Information System was published in the Federal Register. These system requirements are the uniform diagnostic coding system (ICD-9-CM) conversion claim form for inpatient and outpatient hospital billing (HCFA-1450) and a uniform electronic billing format for institutional billing.
- During FY 1985, the HHS Secretary signed and sent to EOMB, a regulation which implements the Schweiker provision for the Medicaid Management Information System conditions of approval and reapproval.

8. RESEARCH, DEMONSTRATION, AND STATISTICAL ANALYSIS

This function provides evidence for the cost-effectiveness, administrative feasibility and effect on beneficiaries and providers of proposed changes in the Medicare and Medicaid programs prior to program-wide adoption. Specific activities include:

- Development, conduct and evaluation of experiments, demonstrations, and research projects to assess the impact of contemplated changes in the Medicare and Medicaid programs.
- Conduct of Congressionally mandated studies (e.g., concerning PPS issues).
- Development of legislative and regulatory proposals, economic and statistical analyses, and the design of research/evaluation projects.

- Dissemination of program data and statistics on utilization, expenditures and access to services.
- Maintenance of the Medicare Statistical Systems.
- Development of statistical data standards and monitoring of the quality of data collection activities in the Medicare program.
- Formulation of overall health data policies for the Agency.
- Preparation of the Trustees' Reports on the status of HI and SMI Trust Funds.
- Preparation of Medicare and Medicaid budget projections.
- Preparation of estimates of the cost of legislative and regulatory changes for the Medicare and Medicaid programs.
- Determination of budget neutrality for determining PPS rates for FY 1984 and FY 1985.
- Preparation of economic price indices for payments to Medicare providers under PPS and TEFRA.
- Develop of final national AAPCC ratebooks.
- Preparation of historic estimates and projections of national health expenditures.
- Collection, maintenance and dissemination of Medicaid data and providing of technical assistance and consultation to users of the data.
- Providing actuarial and economic consultation and assistance to EOMB, Congress, and States, as well as within HCFA and HHS.

Major Highlights/Significant Accomplishments

- Conducting 18 Congressional mandated studies on PPS.
- Developed and implemented a system for collecting procedure-specific physician and supplier data to conduct studies on physician payment reform.
- Conducted studies linking Part A and Part B data to study the feasibility of reimbursing physicians providing inpatient services on a DRG basic.
- In FY 1985, HCFA will serve as fiscal intermediary for 12 demonstration projects and one migrant hospital disbursing $58 million in benefit payments. There will be about 325,000 claims processed and over 200 cost reports settled.
- Each year, Trustees' Reports on the status of HI and SMI Trust Funds are prepared and submitted to Congress.

- Each year, the amount of the Medicare and Part B deductible, premium levels in Parts A and B, the Part B economic index, and the ESRD composite rates are updated.

- Determined the final FY 1984 prospective payment system (PPS) payment rates and the proposed and final PPS payment rates for FY 1985. These rates were set to be budget neutral with the payments that we determined would have been made under the TEFRA provisions.

- In FY 1985, HCFA developed a national AAPCC ratebook which, upon certification by the Secretary of HHS, implemented Section 114 of TEFRA. HMO/CMP's are now allowed to enter into risk contracts with HCFA to provide services to their Medicare enrollees.
- Ten budget projections of Medicaid expenditures were made. over 200 estimates of proposed legislation and regulatory impacts were done relating to the Medicaid program.

- The Medicaid Forecasting System has been implemented on the mainframe and enhanced.

- The Med Stat System, giving States the option to submit a tape sample of Medicaid claim statistics, was intiated. The implementation of this system will be a major effort for the next few years. The Med Stat System will make a dramatic improvement to Medicaid data.

- The 1984 Medicare-Medicaid Data Book and the 1983 Analysis of State Medicaid Program Characteristics were prepared.

- Conducted research on alternative secnarios for calculating and updating input price indices which are used in market basket applications under PPS and TEFRA.

- Commenced a benchmark revision of the National Health Expenditure Accounts.

- Developed, designed, and implemented, as a regulatory proposal in the Federal Register, an analytical framework for updating PPS rates starting in FY 1986.

- Prepared four articles for publication in the HCFA Review on national health expenditures including age and State disaggregates and analyses of causes of rises in health costs.

9. PROGRAM MANAGEMENT SYSTEMS DEVELOPMENT AND MAINTENANCE

This function maintains the Medicare/Medicaid information bases on entitlement, premiums, deductibles, utilization, provider certification, and other operational items. It also involves the assessment of programmatic ADP systems. Specific activities include:

- Operation of the Medicare ADP systems that maintain beneficiary entitlement and utilization records; and maintenance of the data file on provider certification and SMI premium collections.

- Operation of other program systems which support many of HCFA's major cost control activities (e.g., MEQC).
- Electrionic processing and issuance of Medicare cards, Part A utilization notices, and Part B benefit explanations.
- Conduct of initial certifications and subsequent System Performance Reviews of Medicaid Management Information Systems.
- Development of recommendations on proposed acquisitions of EDP hardware/software by Medicare contractors.
- Operation of the State Buy-In Program for Medicare/Medicaid eligibles, maintenance of the buy-in master file, and the billing and collection of approximately $42 million per month for SMI premiums under State Buy-In.

Major Highlights/Significant Accomplishments

Medicare

- During FY 1983, the Medicare direct billing and collection functions were successfully transferred from SSA to a private bank under contract to HCFA, saving about $1.5 million annually. Beginning in FY 1985, the collection function was performed through a Treasury Department network "lock box" bank. In FY 1985, HCFA entered into a separate private sector contract for the billing function.
- Designed and implemented processes for monitoring the newly enacted prospective payment system.
- Provided technical assistance and statistical and raw data files to Congress, other governmental agencies, and to the public (GAO, PROPAC, OIG, OTA, CBO, OCHAMPUS) concerning all aspects of the prospective payment system.
- The System to Provide Immediate Data on Eligibility for Reimbursement (SPIDER) project is proceeding successfully. Phase I (query and admission) has been implemented and by December 1984, approximately 44 Arizona hospitals were using the facility. Phases II and III (inpatient/SNF and outpatient bill processing) are underway. Inpatient/SNF processing is scheduled for completion in July 1985, with outpatient processing to follow.

- In FY 1984 and FY 1985 HCFA implemented the UB-82, a uniform bill for providers. The form is now used by institutional providers in all States in the Medicare program and in 36 States in their Medicaid programs. Other types of providers are being added during FY 1985.

- Based on the conversion to the UB-82 and the need to provide additional data elements to the PROs, HCFA revised the patient billing record. The revised billing format will be called UNIBILL and will be implemented nationwide for Medicare intermediaries by September 1985.

- Under cash management initiatives, HCFA began negotiations to collect State buy-in premiums of $42 million monthly through the automated Treasury Financial Communication System (TFCS) in order to improve the timeliness of the collection process. TFCS started in FY 1985 with 24 States. The remaining States that could not utilize the system, as well as other third party groups were brought under the Treasury Department "lock box" network.

- HCFA is responsible for the establishment and maintenance of a master file of beneficiaries. The master file is "queried" by the intermediaries and carriers prior to claims payment in order to confirm a beneficiary's entitlement and to determine the amount of deductible to withhold and any other limitations on coverage. In FY 1984, over 56 million records were maintained.

- During FY 1985, HCFA has received data from, and provided data to 103 Medicare Contractors. Processed 126,000,000 queries, 47,000,000 bills, and 120,000,000 physician payments. These queries inform the carriers and intermediaries of a claimant's entitlement to benefits and any deductible amounts to be collected or limitations on coverage for appropriate reimbursement.

- HCFA maintains a contractor workload reporting system to track performance in areas such as claims processed, electronic claims submission, Medicare Secondary Payor, assignment rates, claims denials, appeals, and audit activities.

- HCFA has begun a major effort to collect outstanding Part B State Buy-In Premiums. HCFA developed a proposal to encourage timely payment through the use of interest penalties and offset of overdue premiums against State Medicaid grants. This proposal will be published in the Federal Register in June 1985. Premium arrearages have already dropped significantly due to informal notification to the States of the proposed policy change.

- Developed and conducted Intermediary Systems Test to ensure conformance of intermediary bill processing systems with HCFA requirements.
- Standard PS&R system developed by Connecticut BC. System will be mandated for all intermediaries 9/30/85 to eliminate provider burden in maintaining Medicare log.
- Development of Standard HHA Subsystem by Prudential which will be available for use by designated HHA intermediaries in lieu of costly enhancements to existing individual systems.
- During FY 1985, a claims processing consortium was developed to combine the processing requirements from three contractors into a single centralized data processing operation.
- In FY 1985, a cooperative claims processing group was initiated to share the development and maintenance of a compatible data processing system. The systems software is being transferred from existing contractors to groups of five or more contrators who will share the cost of this responsibility.
- During FY 1985, HCFA will introduce prepayment edit modules to standardize the processing functions for specific types of claims.
- Despite relatively small amounts of budget money available to the contrators in FY 1985, it is estimated that by the end of FY 1985 the percentage of Electronic Media Claims (EMC) will increase from 43 percent (FY 1984) to 50 percent for intermediaries and from 18.5 percent to 20 percent for carriers.

Medicaid

- Conducted annual review of 39 States with a certified Medicaid Management Information System (MMIS) to determine whether the system is operating according to Federal guidelines.
- Signed contract for implementation of Bill Processing System Test (BPST) in five States to provide in-dept data related to processing errors and corrective action.
- With the impending certification of the State of Maryland, 44 States and the District of Columbia will have certified Medicaid Management Information Systems (MMIS), entitling them to receive 75 percent Federal financial participation (FFP) for the operation of their system.

HCFA Data Center

- In FY 1984, HCFA's Data Center processed over 179,000 jobs. In FY 1985, the Center will be expanded to consolidate all program management, research and statistical information resources.

10. PROGRAM INSTRUCTION/TECHNICAL ASSISTANCE

This function embodies the responsibility for communicating HCFA's program policies and procedures to beneficiaries and providers and ensures uniformity in treatment of Medicare/Medicaid coverage, eligibility and reimbursement issues, resulting in reduced administrative costs. In addition to ensuring compliance with all relevant laws and regulations, technical assistance provides a vehicle for the resolution of operating problems identified by GAO, health care providers, or program beneficiaries. In performing this function, HCFA staff:

- Develop, issue and maintain policy interpretations and revisions of manuals used by contractors, State Agencies and providers.
- Develop and issue requirements for processing Medicare/Medicaid claims.
- Provide technical assistance to State Medicaid Agencies and Medicare contractors.

Major Highlights/Significant Accomplishments

- In FY 1985, HCFA staff will issue approximately 570 policy issuances to States and Contractors.
- FY 1985 Issuances will include:
  - Prospective Payment System Instructional Material
  - New Manuals for HMOs and PROs
  - Reorganized State Operations Manuals
  - Hospice Instructions
  - Implementing Hepatitis B Instructions
  - Revised Outpatient Reasonable Charge Instructions
  - Revised Provider-Based Physician Instructions
  - Medicaid Eligibility on Pregnant Women and Children Instructions
  - Physician Freeze Instructions
  - Clinical Diagnostic Laboratory Billing Instructions
  - Updated UB-82 instructions for HHA's, SNF's and hospitals
  - Revised Medicare Bill Record Instructions
  - Electronic Media Claims Instructions
  - Medicare Secondary Payer Instructions
  - Redesigned Explanation of Medicare Benefits (EOMB)
  - Durable Medical Equipment under the Home Health Benefit
  - Instructions to implement MQC under TEFRA.
- In FY 1984, HCFA, in cooperation with State Medicaid officials, health professionals organizations and consumer groups, completely redesigned the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Implementation activities will continue into FY 1985, based on revised regulations and new guidelines.
- UB-82 instructions for use of claims by ESRD and CORFS, Outpatient PT and RHC Providers.

- Requirement for ICD-9-CM coding of diagnoses on all provider claims.
- Developed electronic format for HHA plan of treatment and medical information required for intermediary medical review of claims to facilitate EMC.
- Instructions implementing clinical diagnostic laboratory provisions of DRA for ESRD patients.

11. LEGISLATION AND CONGRESSIONAL AFFAIRS

This function provides support to the Secretary, the Assistant Secretary for Legislation (ASL), the HCFA Adminstrator and HCFA senior staff, in planning and managing legislative operations of the Agency. It provides the capability for responding to Congressional legislative initiatves related to health care financing programs and maintains liaison with the Congress on legislative and budget proposals affecting these programs. In addition, the function includes legislative and policy development through the performance of policy relevant studies of health care financing issues and the review and development of legislative budget proposals. Specific activities include:

- The planning and coordination (with ASL) of Congressional briefing sessions and preparation of Congressional hearings.
- Technical assistance to the Department and Congress during Committee mark-up and other Congressional activity on HCFA programs.
- The preparation of briefing books, materials and reports on Congressional issues.
- Conduct briefing sessions for HCFA officials and Congressional staff.
- Provision of legislative research and information services, including management of HCFA's legislative reference library.
- Performance of long and short-range policy analyses in such areas as prospective payment systems; Medicaid coverage and eligibility; long-term care alternatives and physician reimbursement reforms.

Major Highlights/Significant Accomplishments

- Development or analysis of over 70 legislative proposals for technical changes and major program initiatives under Medicare and Medicaid, including significant cost saving proposals.
- Prepare testimony and supporting materials for over 40 Congressional hearings on HCFA programs and Administration initiatives.
- Development of major policy studies on prospecitive payment systems for Skilled Nursing Facilities and physician reimbursement reforms.
- Preparation of over 100 bill reports and bill report clearances for legislation introduced in Congress.

- Participation in hundreds of meetings and briefing sessions for Members of Congress and their staffs to address specific Congressional concerns and support legislative development activities.

- Provision of liaison and technical assistance to Congressional staff on constituent case work and inquiries.

- Responding to more than 3,800 Congressional telephone and written inquiries concerning HCFA Programs.

12. PROGRAM COMMUNICATIONS AND BENEFICIARY SERVICES

The amount of program dollars and the number of individuals, organizations and health care providers affected by the Medicare and Medicaid programs make this activity one of the most important functions of the Agency. Responses to inquiries often interpret or clarify laws, regulations or program guidelines with a potential impact on large numbers of beneficiaries and a direct impact on significant amounts of program dollars. Public information activities promote beneficiary awareness of cost-effective practices. Liaison activities with health care organizations, State and local governments and other interested parties serve to alert the Administrator of sensitive/critical situations. In performing this function, HCFA staff:

- Respond to written and telephone inquiries.

- Prepare and distribute press releases, public service announcements and mailings to beneficiaries.

- Conduct meetings and conferences with beneficiary groups, professional and scientific organizations, State and local officials, and insurance companies to promote special initiatives and to explore ways to manage HCFA's programs more effectively and efficiently.

Major Highlights/Significant Accomplishments

- During 1985 the Agency will respond to more than 500 calls over the prospective payment hotline.

- HCFA meets with beneficiary advocacy groups on a variety of issues of mutual concern, e.g., Explanation of Medicare Benefits (EOMB) formats, toll-free telephone services, and listings of physicians accepting assignment under the Medicare program. These activities will be strengthened during FY 1985 and FY 1986.

- During FY 1985, HCFA will process approximately 500,000 pieces of correspondence, including responses to general public inquiries, Congressional/White House inquiries (19,000), Freedom of Information Act requests (48,000) and intergovernmental inquiries (61,000).

- Those eligible for enrollment in the 1985 General Enrollment Period were selected for mail contact. Enrollment packages were mailed in early Fedbuary to 86,147 domestic and 11,606 Puerto Rican potential enrollees for SMI.

- In October 1984, approximately 29.9 million individual notices were mailed to Medicare enrollees. These notices explained the participating physician/supplier concept, the availability of participating physician/supplier directories at SSA, RRB, senior citizen organizations, and Area Agency on Aging Offices. The notices also contained information on the physician fee freeze and provided the name, address, and local and toll-free telephone numbers of the Medicare carrier where beneficaires could get additional information. Again, in 1985, a mass mailing will be made to notify enrollees of the participating physician/supplier concept and the availability of participating physician/supplier directories.

- During the December 1984 and January 1985 period, notices were released to the entire Medicare beneficiary population (approximately 30 million). These notices informed them of the annual increases in the inpatient hospital deductible, coinsurance amounts, and SMI premium rates.

- Manualized Medicare carrier procedures and standards were released in FY 1985 on improvements to beneficiary services. These instructions require carriers to:

  - provide toll-free and local telephone service for beneficiary inquiries.
  - establish and maintain a minimum busy signal standard of P-20 (caller has no more than a 20 percent chance of getting a busy signal).
  - maintain specific standards for handling written and walk-in inquiries.
  - meet standards for accuracy and timeliness of carrier responses to beneficiaries.

13. ADMINISTRATIVE SUPPORT

This function embraces many responsibilities mandated by law, regulation or external sources, such as the Office of Management and Budget (OMB), Department of Treasury, Office of Personnel Management (OPM) or General Accounting Office (GAO). Specific activities include:

- Formulation and management of the program and administrative budget submissions; development and maintenance of financial management systems, payroll and accounting operations.

- Administration of HCFA grants and contracts activities to ensure compliance with relevant laws, regulations and other administrative requirements.

- Provision of general administrative services, including management and control of real and personal property, security, printing, teleconferencing, etc.

- Administration of the personnel/position management activity.

- Planning and coordination of management activities such as paperwork burden reduction, workplanning, delegations of authority, organizational analyses and A-76 studies to determine the cost-effectiveness of contractor vs. government employee performance of work.

- Operation and management of administrative management computer systems; provision of centralized ADP/telecommunications support.

- Performance of liaison and administrative support activities for the regional offices.

- Participate in workgroup with the Inspector General's office to develop a model type of criteria edits for the detection of fraud.

- Management, development, and implementation of HCFA's Equal Opportunity Programs.

- Process Medicare-related correspondence and ADP exceptions generated by the Health Insurance System.

Major Highlights/Significant Accomplishments

Budget

- Three budget submissions (to OS, OMB, and Congress) are prepared annually. In FY 1986, the combined budget for Medicare and Medicaid will exceed $100.0 billion under current law and cover more than 50 million people in the Medicare and Medicaid programs.

- Multiple apportionments are prepared annually for HCFA's three appropriations: Grants to States for Medicaid ($21.8 billion); Payments to the Health Care Trust Funds ($23.4 billion); and Program Management ($1.2 billion).

- Twenty-one allotments and 107 allowances for each initial apportionment or continuing resolution are prepared annually.

- Thirteen status of funds reports and 26 biweekly employment reports are prepared annually. Individual ceiling allocations are issued for Bureaus and Offices; special analyses of staffing levels and requirements in selected areas are completed as needed.

- Administrative costs are allocated on an ongoing basis between the Medicare Trust Funds and General Treasury Revenues.

Accounting

- Approximately 1,700 daily and periodic financial reports are processed and reconciled annually.

- Approximately 322,000 financial transactions are processed annually.
- Approximately 12,000 vendor invoices and 31,000 letter-of-credit payment vouchers are audited and paid annually.

Management

- Public information requests are cleared through the Office of Management and Budget, as required by the Paperwork Reduction Act. HCFA projects the Public Reporting Burden will reduced by 5.5 million hours in FY 1985.
- Over 40 internal management audits are conducted annually.
- Approximately 2,000 pages of HCFA issuances are managed and updated annually.

Personnel

- Approximately 4,500 personnel actions and 560 labor/management actions are processed annually.
- Approximately 1,500 classification activities are performed annually.

Procurement/Grants

- Approximately 600 contract awards and modifications are completed annually.
- Approximately 900 grant awards, modifications, and continuations are completed annually.
- Substantially exceeded Procurement Preference Program, Even Scheduling and Competitive Award goals in FY 1984.
- Achieved documented savings of more than $53 million in negotiations of contract and grant awards in FY 1984.

Administrative Services

- Implemented a master housing plan which will release two buildings and allow HCFA to meet its 135 square foot per person goal in FY 1985.
- Implemented an employee physicial examination program which has identified potential problems such as cholesterol, triglycerides, diabetes, etc.
- Establish and manage a freeze-frame teleconferencing system between Baltimore, Washington, D.C., and the 10 regions.
- Processes approximately 1900 printing requirsitions annually and procures approximately $11M of printing through GPO.
- Prints and distributes 260 million forms annually to 2,000 Medicare form users nationwide at a cost of $3.5M.

Operations Support

- Process 142,000 annual inquiries and exceptions involving the enrollment and entitlement of Medicare.
- Process 35,000 annual inquiries and exceptions involving Medicare Part B and Part B utilization data.
- Process 575,000 annual requests for data entry and microfilm services.
- Process 102,000 annual inquiries and exceptions involving Medicare premium payment from groups, e.g., United Mine Workers.
- Process 305,000 annual inquiries and exceptions involving Medicaare premium payment from beneficiaries.

Automatic Data Processing

- HCFA has selected the new systems design concept for its long-range automatic data processing environment. This concept encompasses the use of data base management systems (DBMS) technology; the integration of major data bases; and increased office automation.

14. EXECUTIVE DIRECTION

This function is critical to the overall effectiveness and efficiency of the Agency in meeting its obligations to administer the Medicare and Medicaid programs and related provisions of the Social Security Act. These activities direct the planning, coordination and implementation of the operational programs and the development of effective relationships between these programs and other Federally supported health programs. In performing this function, executive staff: